

A QUALITATIVE STUDY ON THE IMPACT OF A SHORT-TERM GLOBAL
HEALTHCARE IMMERSION EXPERIENCE IN BACHELOR OF SCIENCE NURSING
STUDENTS

BY

Copyright 2013

KATHRYN HUTCHINS CZANDERNA

Submitted to the graduate degree program in Nursing
and the Graduate Faculty of the University of Kansas in partial fulfillment of the
requirements for the degree of Doctor of Philosophy.

Chairperson Marjorie J. Bott, RN, MA, PhD

Elaine Williams Domian, PhD, APRN, FNP-BC

Wanda Bonnel, RN, PhD, GNP-BC, ANEF

Martha B. Baird, PhD, APRN, CTN-A

Ellen P. Averett, PhD, MHSA

Robert L. Lee, PhD

Date Defended: May 10, 2013

The Dissertation Committee for KATHRYN HUTCHINS CZANDERNA

certifies that this is the approved version of the following dissertation:

A QUALITATIVE STUDY ON THE IMPACT OF A SHORT-TERM GLOBAL
HEALTHCARE IMMERSION EXPERIENCE IN BACHELOR OF SCIENCE NURSING
STUDENTS

Chairperson Marjorie J. Bott, RN, MA, PhD

Date approved: May 17, 2013

Abstract

The effects of globalization are impacting the healthcare arena. Global healthcare immersion experiences (GHIE) may be a means for nursing students to develop a global perspective. The gap in the literature relates to student perceptions in preparation, cultural interface, and post-immersion experiences. Using Jeffrey's Cultural Competence and Confidence model as the organizing framework, this qualitative descriptive study describes essential components in designing a short-term GHIE for Bachelor of Science in Nursing (BSN) students that will enhance professional development in cultural understanding and global awareness for nursing practice. The study sample ($N = 9$) was selected purposely from senior-level BSN students enrolled in a clinical course with a study abroad option at a Midwestern university. Inductive qualitative content analysis was utilized to determine patterns and themes in the data. Data from focus groups, informal participant interviews, field notes, and observations were analyzed.

Four themes emerged in the pre-immersion phase: (a) *Using personal strengths and desires to help move past barriers in preparation for global immersion experiences*; (b) *Garnering an understanding in completing academic and personal requirements in preparation for a global immersion experience*; (c) *Identifying critical faculty/organizational supports in promoting a successful global immersion experience*; and (d) *Moving through early stages/phases of cultural competence in preparation for global immersion experiences*. Four themes also emerged in the post-immersion phase: (a) *Reflections on the usefulness/benefits of pre-immersion activities and behaviors in preparing for the immersion experience*; (b) *Acknowledging and identifying cultural and other stressors in order to have meaningful clinical and personal experiences during a global immersion experience*; (c) *Moving past re-entry*

adjustment in seeking meaningful reflection of the personal and professional impact of the immersion experience; and (d) Restructuring organizational processes and academic programs needed in order to ensure success of future global immersion programs.

Findings from the study provide insight into key elements necessary in the planning, cultural interface, and post-immersion phases of global immersion experiences for BSN students. This includes the importance of key people, educational concerns, and the availability of an international resource office. Implications of the study related to students, faculty, practice limitations, academics, and organizational concerns were presented.

Acknowledgements

Overall, I have enjoyed the process of completing my doctoral studies. I have learned much and been influenced in different ways from each of my professors.

I am deeply grateful for the expertise of my dissertation committee members. Dr. Marge Bott has been my academic advisor and dissertation chair. Dr. Elaine Domian has been my minor professor and qualitative research expert. I have worked closely with Dr. Bott and Dr. Domian throughout the process of completing my dissertation and have seen collegiality exemplified by their team approach in leading, guiding, and encouraging me in my endeavors. I have only the deepest respect and appreciation for their expert assistance and superb role modeling. I cannot thank them enough. In addition, I am appreciative of Dr. Wanda Bonnel's knowledge of nursing education, Dr. Martha Baird's passion for global health, Dr. Ellen Averett's expertise in global health policy and management, and for Dr. Robert Lee's expert guidance as the graduate school representative as well as his knowledge of health policy.

I am thankful for the students who chose to participate in my study, for their candor, and exuberance in sharing their stories. I want to acknowledge Vicki L. Hicks, RN, MS, APRN, and Nancy K. Barr, RN, MS, the international practicum faculty, who helped me in multiple ways during the study. Cheryl Spittler, PhD, RN, and Regina (Gina) Johnson, MSN, RN, were a great source of support through their help as research assistants as well.

My husband, Joseph, has been on this journey with me from its inception. There is no way to fully express my love and appreciation for his ongoing support throughout this process. I could not have done this without his unwavering confidence in me. I know my Mom and Dad would have been proud of me as well. To the rest of my great family, dear friends, and faithful prayer partners, I say thanks and to God, all praise and glory.

Table of Contents

Acceptance Page	ii
Abstract	iii
Acknowledgements	v
Table of Contents	vi
List of Tables and Figures	x
Chapter One: Introduction to the Problem	1
Background of the Problem	2
Impact of Globalization on Health and Healthcare	2
Issues Related to Health Care Providers and Cultural Competence	4
Significance of the Study	6
Significance of the Study to Nursing	7
Purpose of the Research	8
Research Questions	9
Philosophical Framework	9
Theoretical Framework	10
Assumptions and Limitations of the Study	15
Assumptions of the Study	15
Delimitations and Limitations of the Study	15
Definition of Terms	16
Summary	19
Chapter Two: Review of Relevant Literature	20
Introduction	20
Overview of Literature Pertaining to Non Nursing Programs and Practice Areas	20
Anthropology	21
Education	22
Business and Marketing	24
Foreign Language Teachers, Social Work, Library Science, and Psychology	26
Overview of Literature Pertaining to Nursing Education	29
Organizations and Projects Influencing Nursing Education and Practice	30
Institute of Medicine	31
Nursing Education and Accreditation Organizations	32
Quality and Safety Education for Nurses	33
Nursing Education and Practice Theories	34
The Pedagogy/Andragogy Dichotomy	34
Learning Styles, Experiential Learning, and Situated Learning	36
Significant Learning Experiences and Student Engagement	38
Education for Global Immersion Experiences	41
Overview of Literature Pertaining to Global Healthcare Immersion Experiences	42
Anecdotal/Descriptive Findings	43
General Global Health Programs	44
Educational Programs Focused on Global Health	44
Immersion Experience Outcomes	46
Research Findings	48
Literature Reviews	48

Enhancement of Cultural Competence	51
Model Development.....	56
Short-Term Outcomes.....	58
Long-Term Outcomes.....	60
Summary of the Review.....	63
Summary of Significance to Nursing.....	66
Chapter Three: Methodology	68
Study Design	68
Sample.....	70
Support and Rationale for Sample Size	71
Inclusion/Exclusion Criteria	72
Setting	73
Academic Setting.....	73
Location of the Global Healthcare Immersion Experience.....	74
Human Subject Considerations.....	74
Institutional Review Board Approval	74
Procedures.....	75
Research Consent Forms.....	77
Data Collection	78
Phases of Data Collection	78
Phase I: Pre-Immersion.....	82
Phase II: Immersion	84
Phase III: Post-Immersion.....	84
Focus Group Interview Questions	85
Researcher Training.....	86
Researcher as Instrument	87
Qualitative Analysis.....	87
Demographic Data	87
Description of Study Participants	87
Qualitative Content Analysis Process.....	91
Trustworthiness and Methodological Rigor.....	93
Ethical Considerations	95
Summary	95
Chapter Four: Results	96
Results of Phase One: Pre-Immersion	98
Theme 1: Using Personal Strengths and Desires to Help Move Past Barriers in Preparation for Global Immersion Experiences.....	98
Desire to Travel Abroad.....	98
Prospects for Traveling Abroad.....	99
Family Involvement.....	100
Practical Tips, Guidelines, and Strategies.....	101
Perceived Personal Challenges to Studying Abroad.....	102
Theme 2: Garnering an Understanding in Completing Academic and Personal Requirements in Preparation for a Global Immersion Experience	103
Flexible Attitude	103
Learning Independence	104

Personal Concerns.....	104
Academic and Clinical Requirement Challenges	105
Theme 3: Identifying Critical Faculty/Organizational Supports in Promoting a Successful Global Immersion Experience	107
Perceptions of Sending Organization.....	107
Perceived Lack of Planning by Receiving Organization	109
Interactions with Mentors/Key People.....	109
Theme 4: Moving Through Early Stages/Phases of Cultural Competence in Preparation for Global Immersion Experiences.....	110
Becoming Culturally Aware	111
Cultural Skills and Nursing.....	112
Perceived benefits of study abroad experience	112
Results of Phase Two: Immersion or Cultural Interface.....	114
Results of Phase Three: Post-Immersion	114
Theme 1: Reflections on the Usefulness/Benefits of Pre-Immersion Activities and Behaviors in Preparing for the Immersion Experience	115
Character Traits and Attributes.....	115
Developing Relationships with Primary Key Persons	116
Acquisition of Travel Advice and Tips.....	117
Stressors Related to Academic Requirements	118
Theme 2: Acknowledging and Identifying Cultural and Other Stressors in Order to Have Meaningful Clinical and Personal Experiences During a Global Immersion Experience	119
Moving Through Stages of Cultural Understanding.....	120
Communication Barriers Regarding Clinical Experiences	122
Stressors related to Academic Requirements While Abroad.....	123
Developing Relationships with Secondary Key Persons (e.g., Other Students, International Travelers, and Locals)	124
Positive Mentoring by Healthcare Providers	125
Experiences in the Clinical Setting/Patient Care Experiences.....	126
Theme 3: Moving Past Re-entry Adjustment in Seeking Meaningful Reflection of the Personal and Professional Impact of the Immersion Experience.....	127
Re-entry Fatigue and Adjustment Aids.....	127
Academic and Professional Demands in the Re-entry Period	128
Reflections from Personal Perspective	129
Professional and Healthcare Delivery System Perspectives	130
Theme 4: Restructuring Organizational Processes and Academic Programs Needed in Order to Ensure Success of Future Global Immersion Programs	131
International Resource Person(s)	132
Concerns and Ideas Regarding Immersion Experience	132
Length of Immersion Experience and Suggestions for Change.....	134
Summary	135
Chapter Five: Discussion	136
Research Questions	136
Research Question 1: (Self-efficacy).....	136
Research Question 2: (Cognitive/Practical).....	137

Research Question 3: (Practical/Affective)	139
Research Question 4: (Affective).....	140
Theoretical Relevance.....	141
Discussion of Key/New Findings.....	143
Personal Characteristics and Attributes	143
Concerns, Stressors, and Barriers	145
Personal and Professional Benefits.....	147
Academic and Organizational Perceptions	148
Summary of Findings, Implications, Limitations and Strengths, and Future Research	151
Summary of Key/New Findings	151
Implications for Practice	151
Faculty.....	152
Students.....	153
International Resource Office	154
Practice Limitations	155
Academics and Curriculum.....	156
Limitations and Strengths	157
Suggestions for Future Research	159
Summary	161
References	162
Appendix A: Letter of Invitation	183
Appendix B: Research Consent Form.....	184
Appendix C: Research Consent Form (Post-Immersion Focus Group).....	188
Appendix D: Demographic Questionnaire.....	192
Appendix E: Interview Guide	194
Appendix F: Reflective Journaling of the Researcher	196
Appendix G: Student Reflective Journaling Course Requirements.....	200

List of Tables and Figures

List of Tables

Table 1. Assumptions of Jeffreys' Cultural Competence and Confidence (CCC) Model	13
Table 2. Summary of Data Collection Methods	81
Table 3. Participant Demographics	89
Table 4. List of Themes and Categories	96

List of Figures

Figure 1. Jeffreys' Cultural Competence and Confidence (CCC) Model.....	12
---	----

Chapter One

Introduction to the Problem

The effects of globalization continue to impact the healthcare arena necessitating that nurses develop a global healthcare perspective. Global healthcare immersion experiences may be a means for nurses and nursing students to gain proficiency in cultural understanding and global awareness. The educational setting is an ideal place for this to occur as it is imperative that future healthcare providers become culturally competent to practice adequately in today's culturally- and ethnically-diverse environment.

The purpose of this chapter is to provide background information and the significance of the problem by discussing the impact of globalization on healthcare and issues related to healthcare providers and cultural competence. Moreover, a discussion regarding the significance of the study to nursing is included. A rationale for conducting a qualitative study is provided as well as a brief discussion of the philosophical framework chosen for the study (e.g., a qualitative descriptive approach). Jeffreys' cultural competence and confidence (CCC) model (Douglas & Pacquiao, 2010b; Online Journal of Cultural Competence in Nursing and Healthcare.org [OJCCNH.org], 2013) will be utilized as the organizing framework for the study. The rationale for choosing this model along with information pertaining to its key constructs (e.g., cognitive, practical, and affective learning dimensions) (Douglas & Pacquiao, 2010b; OJCCNH.org, 2013 [formerly the Cultural Competence Project website]) along with assumptions of the model will be addressed. Moreover, assumptions specific to the research will be included. Terms pertinent to the study are identified and defined. A brief summary of the chapter will follow.

Background of the Problem

Impact of Globalization on Health and Healthcare

Since the 1980s, international attention increasingly has been focused on the swift spread of globalization (Babones & Babcicky, 2010; Cornia, 2001; Fidler, 2001; World Health Organization [WHO], 2013b). The driving force for the growth of the phenomenon of globalization, defined in this context as a connectedness and an interdependence amongst nations, businesses, and people (Fidler, 2001; Labonte & Schrecker, 2005; WHO, 2013b), is associated primarily with worldwide economic changes that have occurred through the support of organizations such as the International Monetary Fund, the World Bank, the World Trade Organization, and a myriad of transnational companies (Labonte & Torgerson, 2005; Lee et al., 2007; McMichael & Beaglehole, 2000; WHO, 2012; Woodward, Drager, Beaglehole, & Lipson, 2001). Components deemed important to the spread of globalization include the associated dominance of deregulated trade markets along with significant changes in the distribution of wealth; rapid advances in information and communication technologies; and western dominance of the popular culture related to consumer behaviors such as diets, physical activity patterns, and associated lifestyle changes. All of these have the potential to significantly affect the health outcomes of the world's population, a nation, or an individual (Babones & Babcicky, 2010; Falk-Rafael, 2006; Kaul & Faust, 2001; Kokko, 2011; McMichael & Beaglehole, 2000; WHO, 2012).

The influence globalization has on health is complex and presents significant challenges around the world (Babones & Babcicky, 2010; Commission on Social Determinants of Health, 2008; Cornia, 2001; Falk-Rafael, 2006). Broadly, changes in the global environment and climate engender long-term health risks as evidenced by the following: ozone depletion and the increase of skin cancers; ecological alterations (e.g., loss of plant and animal species) related to human's

increased need for space, natural resources, and food; and the destruction of ecosystems that produces food (Commission on Social Determinants of Health, 2008; Kaul & Faust, 2001; McMichael & Beaglehole, 2000). In addition, there is an insidious and nearly imperceptible effect on health related to income distribution, unpredictability of economic and financial growth, and political instability as demonstrated by health status changes from financial hardships such as unemployment and subsequent loss of health insurance; increases in stress-related deaths such as with homicides, suicides, and cardiac events; and diminishing social cohesion and its' effect on family structures (Babones & Babcicky, 2010; Cornia, 2001; Falk-Rafael, 2006; Kaul & Faust, 2001; Labonte & Torgerson, 2005).

The effects of globalization are impacting the healthcare arena where there are challenges such as migration of healthcare providers from developing to developed countries, disease transmission across international boundaries, poor health outcomes despite improvements in technology, changes to social determinants of health (e.g., circumstances in which people live and work, including access to healthcare [WHO, 2013c]), and an increased need for collaboration among healthcare policy makers worldwide (Commission on Social Determinants of Health, 2007; 2008; Giger et al., 2007; Huston, 2008; Kaul & Faust, 2001; Labonte & Schrecker, 2005; Labonte & Torgerson, 2005; Lee et al., 2007; Leininger, 1997; Wells, 2000; WHO, 2012; Woodward et al., 2001). Furthermore, diffusion of cultural practices across international borders is occurring because of changing social processes that result in increased numbers of people seeking opportunities outside of their country of origin, such as in the United States of America (USA) (Giger et al., 2007; Kokko, 2011; Labonte & Schrecker, 2005; Wells, 2000; Woodward et al., 2001). Demographics are changing in the USA as noted by more culturally distinct and larger ethnic groups, thus providing additional support for the trends noted

above (Giger et al., 2007; Kokko, 2011; Smith & Curry, 2011; Wells, 2000). In essence, the relationship between globalization and health serves as a directive for nurses to have greater involvement globally (Babones & Babcicky, 2010; Falk-Rafael, 2006; WHO, 2012).

Issues Related to Healthcare Providers and Cultural Competence

The nation's call for comprehensive modifications in the delivery of healthcare services attests to the dramatic changes in the healthcare needs of the public that have occurred over the past decade (Giger et al., 2007; Institute of Medicine [IOM], 2001; 2011). Strategies for improving the healthcare delivery system that were identified by the Institute of Medicine (IOM, 2001) and that focused on safe, efficient, effective, patient-centered, timely, and equitable care are still appropriate today. In addition, the way in which healthcare workers are trained and prepared has great importance to the improvement of quality and culturally-sensitive care (Giger et al., 2007; IOM, 2001; 2011; Plsek, 1997). Specifically, it is vital for healthcare providers to be culturally competent (defined as the process of developing the ability to work within the cultural context of the client) (Campinha Bacote, 2007), in order to effectively communicate with and care for culturally and ethnically diverse patient populations (American Nurses Association, 2013; Giger et al., 2007; Huston, 2008; Kim, Woith, Otten, & McElmurry, 2006; Kokko, 2011; Kulbok, Glick, Mitchell, & Greiner, 2012; Smith & Curry, 2011; Wells, 2000). Nowhere does this hold greater significance than with nurses; they comprise one of the largest bodies of healthcare providers with 3.1 million registered nurses (R.N.s) in the United States of America (USA) (American Nurses Association, 2013) and more than 13 million nurses worldwide (International Council of Nurses, 2013). The development of innovative approaches to meet these challenges is essential (IOM, 2001; National League for Nursing [NLN], 2003; Plsek, 1997; Smith & Curry, 2011).

It is necessary for nurses to be able to adapt and change in order to function effectively in the midst of evolving healthcare needs in diverse patient populations. Nurse educators, at the forefront of training future healthcare providers, can help lead the way in achieving these objectives. Indeed, the missions of the National League for Nursing (NLN, 2003) as well as the American Association of Colleges of Nursing (AACN) (AACN, 2013b; 2013c) seek to enhance and support nursing educational endeavors. In addition, these organizations stipulate that nursing programs incorporate aspects of global health including subjects relevant to the development of cultural competence (AACN, 2008; NLN, 2003; 2005). Curricular designs that include significant learning experiences centered on global health not only will meet accreditation guidelines, but will help prepare students to care for the increased numbers of diverse patients. In turn, quality of care given to patients as well as improved health outcomes of culturally and ethnically varied patient populations will likely occur (AACN, 2008; Campinha-Bacote, 1999; Commission on Collegiate Nursing Education, 2009; Giger et al., 2007; Kardong-Edgren, 2007; Kardong-Edgren & Campinha-Bacote, 2008; Kulbok et al., 2012; NLN, 2003; National League for Nursing Accrediting Commission, Inc.[NLNAC], 2012; Ungos & Thomas, 2008; Wells, 2000).

It follows that participation in a short-term global healthcare immersion experience could initiate and support a lifelong process whereby nurses might gain proficiency in cultural understanding. A key place for this to occur is in the educational setting, during a nurse's formative years where nurse educators can help lead the way in creating innovative learning experiences with a global health focus.

Significance of the Study

Based on the above, it is not surprising that greater attention is being given to health on the global agenda (Commission on Social Determinants of Health, 2007; 2008; Falk-Rafael, 2006; Kaul & Faust, 2001; WHO, 2012). The call for international collaboration (e.g., partnerships) in health and healthcare, therefore, is necessary in today's increasingly connected and interdependent world (Huston, 2008; Kaul & Faust, 2001; Kulbok et al., 2012; Labonte & Schrecker, 2005). Moreover, every domain of healthcare (e.g., policy efforts, provision of services, and educational endeavors) needs to be strengthened in response to the complex challenges present today (Drager & Beaglehole, 2001; Howarth, Holland, & Grant, 2006; Huston, 2008; Kokko, 2011; Labonte & Torgerson, 2005; WHO, 2012). A new workforce is needed as well and should include all healthcare workers, (specifically nurses for this study), who are knowledgeable in understanding how to maximize the positive outcomes and are skillful in reducing the harmful effects of globalization on health. Harmful effects include, but are not limited to the following: global public health concerns such as the spread of infectious diseases, narcotic and drug trading on an international level, trans-boundary pollution, and occupational health issues (Commission on Social Determinants of Health, 2007; 2008; Drager & Beaglehole, 2001; Falk-Rafael, 2006; Fidler, 2001; Howarth et al., 2006; Huston, 2008; Mkandawire-Valhmu & Doering, 2012; Wells, 2000; WHO, 2012). The challenge is in finding ways to identify and measure the positive and negative effects of globalization on health and healthcare (Drager & Beaglehole, 2001).

Since research related to the impact of globalization on health is still in the early stages, research studies addressing these critical areas is imperative in order for important health gains to be realized (Commission on Social Determinants of Health, 2007; 2008; Cornia, 2001; Drager &

Beaglehole, 2001; Kaul & Faust, 2001; WHO, 2012). Research that incorporates concepts designed to strengthen healthcare educational efforts as well as to support individual healthcare workers' acquisition of knowledge and development of practical and professional skills in the areas of cultural competence and global awareness will be important in learning more about the complex effects of globalization on health. In addition, the need for professional practice efforts to be evidence-based is supported through this research.

Significance of the Study to Nursing

The professional practice of nursing is being impacted significantly by globalization as evidenced by the increasing numbers of culturally-diverse patients and changing health care needs related to socioeconomic and environmental factors. As a result, nurses are being directed to gain sensitivity in cultural competence through education and training courses (Giger et al., 2007; Howarth et al., 2006; Kokko, 2011; Smith & Curry, 2011). In order to better prepare nurses to function effectively in today's changing world, nursing accreditation bodies are stipulating that graduates of nursing programs have a global perspective (AACN, 2008; NLN, 2003; 2005; NLNAC, 2012). In support of this mandate, this research will examine Bachelor of Science in Nursing (BSN) students' perceptions related to participation in a short-term global healthcare immersion experience. This type of experience potentially is one way to begin to understand the components necessary to prepare nurses and nursing students adequately to help meet the complex challenges of healthcare resulting from globalization. Since nurses are at the vanguard of providing patient care by virtue of their numbers and the diversity of settings where they practice (e.g., hospitals, clinics, educational systems, businesses, and homes) (IOM, 2011; Jairath, 2007), this study not only is timely but has significance for nursing science. The growing body of literature pertinent to global healthcare immersion experiences demonstrates

nurse educators' interests in learning more about the benefits of immersion experiences on the personal lives and professional practice of nurses and nursing students (Button, Green, Tengnah, Johansson, & Baker, 2005; Callister & Cox, 2006; Kokko, 2011; Kulbok et. al, 2012; McAuliffe & Cohen, 2005). The research will add to the body of nursing knowledge as well as contribute to efforts to shift nursing research from centering on health issues with a global component to having a broad global health perspective (Jairath, 2007).

Purpose of the Research

Little is known about the complex healthcare challenges for nurses and nursing students related to the effects of globalization (Commission on Social Determinants of Health, 2007; 2008; Labonte & Schrecker, 2005; Labonte & Torgerson, 2005) as evidenced by a limited amount of research-based literature, and the lack of research building on the findings of previous work in the area of global healthcare immersion experiences (Button et al., 2005; McAuliffe & Cohen, 2005). (A more thorough discussion of the literature will be found in Chapter Two.) In addition, the drive initiated by nursing accreditation organizations stipulating that nursing education programs have a global perspective will be futile unless professional practice is informed through evidence-based research (AACN, 2008; NLN, 2003; 2005; NLNAC, 2012). Nurses must be educated to practice and lead in the arena of global healthcare (Falk-Rafael, 2006; Howarth et al., 2006; Kim et al., 2006; Mkandawire-Valhmu & Doering, 2012; Swenson, Salmon, Wold, & Sibley, 2005).

Using a qualitative descriptive design based on the major concepts (e.g., self-efficacy, cognitive, practical, and affective) of the organizing framework of Jeffreys' cultural competence and confidence (CCC) model (Douglas & Pacquiao, 2010a; 2010b; OJCCNH.org, 2013), the aim of this research is to describe components considered most essential in designing a short-term

global healthcare immersion experience for BSN students that will enhance professional development in nursing practice in the areas of cultural understanding and global awareness. Jeffrey's CCC model categorizes learning into cognitive, practical, and affective dimensions with transcultural self-efficacy as the domain of interest (Jeffreys & Smolaka, 1996; OJCCNH.org, 2013).

Research Questions

The specific research questions that would support this aim are:

1. What is the student perception of his/her ability to perform in a global health setting in the preparation, cultural interface, and post-immersion stages? (Self-efficacy)
2. What is the student perception of the educational information including clinical training that is needed in the preparation, cultural interface, and post-immersion stages of the global health experience? (Cognitive/Practical)
3. What is the student perception of the benefits and the gaps of the mentoring that support their cultural understanding in the preparation, cultural interface, and post-immersion stages of the global health experience? (Practical/Affective)
4. What is the student perception of how they will integrate this global immersion experience into their personal and professional lives? (Affective)

Philosophical Framework

Although qualitative designs involve description that necessitates interpretation, the researcher does not need to move far from the data into an abstract portrayal of its meaning, particularly since a key feature of this type of design is the wide-ranging summary of experiences in common language (Sandelowski, 2000; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). Descriptive studies are considered less theoretical than other qualitative

approaches even though they are apt to draw from the principles of naturalistic inquiry, that is, studying the experience in its' natural state or setting (Sandelowski, 2000).

The use of descriptive designs has applicability to nursing as a whole (Baillie, 1995; Sandelowski, 2000), and specifically for this research. Since it is important in qualitative research to gather as much data as possible in order to capture every component of an event (Sandelowski, 2000) a number of data collection methods are utilized in this study. Examples of data collection methods used to understand the participant perspective include the following: artifacts and observations such as course documents, participant reflective journals, faculty/participant debriefing sessions, field notes, and researcher as instrument (Baillie, 1995; Hodgson, 2001; Patton, 2002; Sandelowski, 2000; Wolf, 2007). Little is known from the participant perspective about the components considered most vital in designing a short-term global healthcare immersion experience that will enhance professional development in nursing practice applicable to cultural competence and awareness of global health concerns. Therefore, a qualitative approach is well-suited in the design of this research.

Theoretical Framework

Jeffreys' cultural competence and confidence (CCC) model has been selected as the organizing framework for this proposed study. Development of the conceptual framework for Jeffreys' CCC model was based on pertinent empirical and conceptual literature from education (Bloom's taxonomy of learning), psychology (Bandura's self-efficacy theory), and transcultural (cross-cultural) nursing literature (Jeffreys, 2000; Jeffreys & Smodlaka, 1996; 1998; 1999; OJCCNH.org, 2013). The model integrates transcultural skills (defined as essential skills for providing culturally congruent care for clients from diverse populations [Jeffreys, 2000; OJCCNH.org, 2013]) in the cognitive, practical, and affective learning dimensions with self-

efficacy (or confidence) as a key influencing factor (Douglas & Pacquiao, 2010a; 2010b; OJCCNH.org, 2013). The framework was developed primarily as a means for exploring the multidimensional elements entailed in the process of learning cultural competence (OJCCNH.org, 2013) such as recognizing individuals at risk for low or too high self-efficacy, developing strategies to help support learning, guiding teaching practice and research, and evaluating effectiveness of teaching-learning strategies (Douglas & Pacquiao, 2010a; 2010b; OJCCNH.org, 2013). Based on the CCC model, key components were selected to guide the proposed study as identified in the aim and research questions. An illustration of the key concepts and dimensions from the CCC model used for this study can be found in *Figure 1*. Assumptions related to the cultural competence and confidence model can be found in *Table 1*. Definitions specific to the model are included in the definition of terms section and labeled as such.

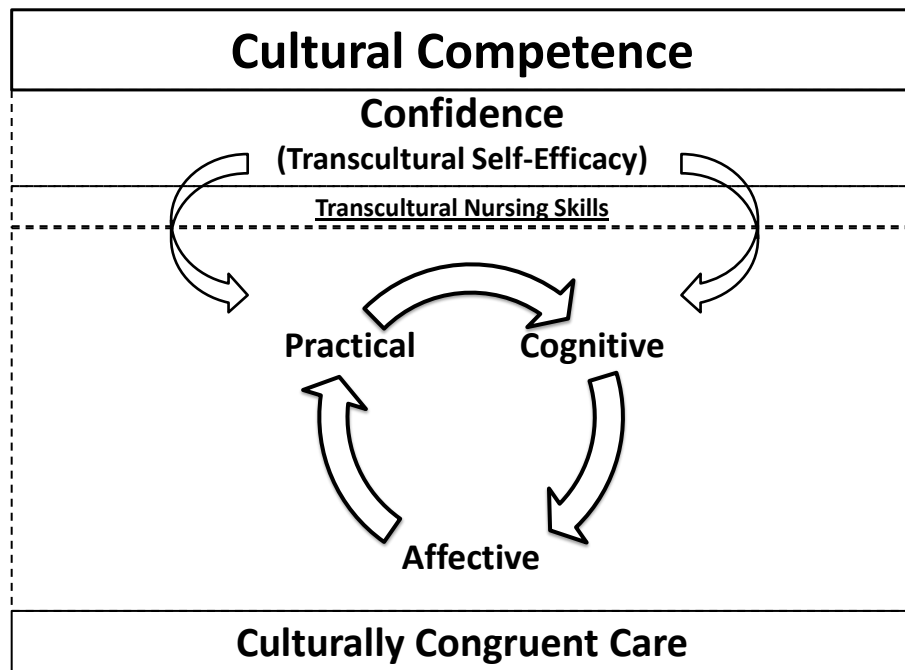


Figure 1. Jeffrey's Cultural Competence and Confidence (CCC) Model. Adapted from Jeffrey, M. R. (2010). *Teaching cultural competence in nursing and health care* (2nd ed.). New York: Springer Publishing Company.

Table 1

Assumptions of Jeffreys' Cultural Competence and Confidence (CCC) Model

-
1. Cultural competence is a continuous, learning process, multidimensional in nature that integrates transcultural skills in the cognitive, practical, and affective dimensions. It involves transcultural self-efficacy (TSE) or confidence as a key influencing element with achievement of culturally appropriate care as the goal.
 2. Valid (formalized) exposure to transcultural nursing (e.g., culture care concepts) influences the dynamic construct of TSE.
 3. TSE perceptions (e.g., confidence) influences the process of learning transcultural nursing skills.
 4. TSE perceptions and satisfactory learning of transcultural nursing skills affects the performance of such skills.
 5. Performance of transcultural nursing skills is influenced by TSE and formalized exposure to culturally congruent nursing educational components.
 6. Formalized transcultural nursing educational experiences are necessary for all students and nurses to meet the needs of culturally diverse individuals.
 7. Learning that involves the assimilation of cognitive, practical, and affective dimensions is comprehensive.
 8. Learning in the cognitive, practical, and affective dimensions is separate yet interconnected.
 9. Learners have greater confidence about their attitudes (affective dimension) and less confidence about their transcultural nursing knowledge (cognitive dimension).
 10. TSE perception will be lower in beginning learners as compared to advanced learners.

11. Individuals lacking TSE are at risk for averting cultural considerations, diminished motivation, and or decreased commitment when planning and implementing transcultural nursing care.
12. Individuals with a high level of TSE (e.g., overly confident) are at risk for making inadequate preparations in learning culturally congruent nursing skills.
13. At-risk individuals will be better prepared to meet competencies in cultural care with early intervention.
14. Individuals with low self-efficacy will experience the greatest change in their TSE perceptions when exposed to formalized transcultural education and experiences.

Note. Assumptions have been adapted from the Douglas and Pacquiao (2010a; 2010b) and OJCCNH.org (2013).

Assumptions and Limitations of the Study

The following assumptions and limitations of the study are outlined below:

Assumptions of the Study

1. Student participants will self-select enrollment in the *Nursing (N) 490 Professional Practicum: Study Abroad Option* course because of personal and/or professional interest in global healthcare issues.
2. Student participation may be supported by financial and personal and/or family provisions.
3. Student participants will prepare for the global healthcare immersion experience as recommended by the host organization and course guidelines as well as faculty instructions.
4. Student participants will be willing and motivated to actively participate in all aspects of the global healthcare immersion experience.

Delimitations and Limitations of the Study

1. Events may occur which affect aspects of the immersion experience that are out of the control of the University, course faculty, and host organization (e.g., civil unrest in the host country).
2. The number of participants able to enroll for the study abroad option experience is limited based on previously established guidelines with organizations in host countries as well as the state board requirement for faculty to student ratios for clinical experiences (Kansas Board of Nursing Nurse Practice Act, 2012).
3. The brevity of the immersion experience does not take into account the time needed to move through phases of culture shock (Ryan & Twibell, 2002).

Definition of Terms

Clarification of key terms used in the literature is necessary prior to synthesizing findings in the literature review found in Chapter Two. The terms international, cross-cultural, and transcultural, similar in meaning, were found in much of the literature. Immersion-type experiences also were described in numerous ways and included such terms as clinical experiences/placements, exchanges, cultural encounters, immersion, participation, partnerships/collaboration, service-learning, short-term medical missions, and study abroad (Amerson, 2010; Bosworth et al., 2006; Button et al., 2005; Kollar & Ailinger, 2002; Koskinen & Tossavainen, 2004; Patterson, 2007; Ryan & Twibell, 2002; Souers, 2007; Torsvik & Hedlund, 2008; Zorn, 1996; Zorn, Ponick, & Peck, 1995).

The Merriam-Webster Online Dictionary describes the term global (2013a) more broadly than international (2013c). In addition, the word immersion is described as education based on widespread exposure to surroundings or conditions that are native or relevant to the object of study (Merriam-Webster Online Dictionary, 2013b). As such, the word immersion is a logical replacement for the terms noted above related to these types of experiences. Furthermore, since the term global is incorporated into baccalaureate nursing education program components (AACN, 2008); is referenced in nursing accreditation guidelines (Commission on Collegiate Nursing Education, 2009; National League for Nursing Accrediting Commission, Inc., 2012); and is a more updated phrase (Kulbok et al., 2012); it is fitting to use the phrase, global healthcare immersion experience, when discussing the findings in the literature. The term healthcare (versus nursing) is used intentionally in an effort to maintain a broader focus in the review.

Therefore, for the purposes of this paper the following definitions will be used for the terms noted below. Definitions related specifically to the cultural competence and confidence (CCC) model will be identified with an asterisk (*).

***Affective learning dimension:** A concept important to the development of professional values and beliefs and involves self-awareness, awareness of cultural differences, appreciation, support, acceptance, and recognition (Douglas & Pacquiao, 2010b; Jeffreys & Smodlaka, 1996; OJCCNH.org, 2013).

Bachelor of Science in Nursing student: A person enrolled in a Bachelor of Science in Nursing (BSN) program of study.

***Cognitive learning dimension:** A concept that pertains to knowledge and understanding, intellectual ability and skills about ways cultural elements may influence professional care of diverse patient populations (Douglas & Pacquiao, 2010b; Jeffreys & Smodlaka, 1996; OJCCNH.org, 2013).

Cultural awareness: A self-examination and careful exploration of assumptions, biases, prejudices, and stereotypes held about others who are different from one's self (Campinha-Bacote, 2007).

***Cultural competence:** A multidimensional learning model that incorporates cognitive, practical, and affective dimensions and involves self-efficacy (confidence) as influencing characteristics of transcultural skills (Douglas & Pacquiao, 2010b; Jeffreys & Smodlaka, 1996; OJCCNH.org, 2013).

Culture shock: An emotional and/or physiological reaction/disorientation or disequilibrium that occurs when a person is immersed in a culture different than one's own and lacks or is deprived of familiar cues for coping with the stress resulting from the immersion experience. It is not

necessarily a singular event, but occurs as part of the process of cultural learning. The nature and duration of the stressful situation as well as the psychological make-up of the person affect the type and intensity of reactions (Furnham, 2010; Paige, 1993a).

Global: A concept pertaining to the world (Labonte & Schrecker, 2005; WHO, 2013b).

Globalization: A connectedness and an interdependence amongst nations, businesses, and people (Falk-Rafael, 2006; Fidler, 2001; Labonte & Schrecker, 2005; WHO, 2013b).

Global health: A collection of health issues recognizing the interconnectedness of the nations that includes acknowledgement of disparities related to changes resulting from globalization (e.g., socioeconomic, environmental, and war) (Commission on Social Determinants of Health, 2007; 2008; Jairath, 2007; Labonte & Schrecker, 2005; Labonte & Torgerson, 2005; Kulbok et al., 2012; WHO, 2013).

Healthcare immersion experience: An event where a healthcare student or provider receives instruction based on widespread exposure to circumstances in a country and/or culture different than one's own.

Healthcare provider: A licensed professional person who provides healthcare to another such as physicians, dentists, nurses, and nursing students, for example.

Immersion: A concept of instruction where an individual goes to another country and/or culture different than one's own to live and work within the local environment that is based on extensive exposure to surroundings or conditions that is native or pertinent to the object of study (Merriam-Webster Online Dictionary, 2013b).

International: A concept pertaining to borders between specific nations (Jairath, 2007; Merriam-Webster Online Dictionary, 2013c).

International health: A collection of health concerns distinctly related to the borders between specific nations (Jairath, 2007; Labonte & Torgerson, 2005).

***Practical learning dimension:** A concept that relates to psychomotor or practical application of skills such as ability to utilize verbal and nonverbal skills in communicating with culturally-diverse clients (Douglas & Pacquiao, 2010b; Jeffreys & Smodlaka, 1996; OJCCNH.org, 2013).

Short-term global healthcare immersion experience: An event based on widespread exposure to circumstances related to the aim of the study lasting from 1 to 4 weeks in duration (Button et al., 2005; Ryan & Twibell, 2002) where a healthcare student or provider receives instruction in another country and/or culture, and is exposed to a new healthcare system.

***Transcultural self-efficacy:** An idea conceptualized as the extent to which an individual deems he/she has the ability to perform the variety of transcultural nursing skills necessary to provide culture-specific care (Jeffreys & Smodlaka; 1996; 1998; OJCCNH.org, 2013).

***Transcultural skills:** A set of essential skills necessary for providing culturally congruent care for clients from diverse populations (Jeffreys, 2000; OJCCNH.org, 2013).

Summary

This chapter provides an introduction to the background and significance of examining BSN students' participation in a short-term global healthcare immersion experience. While nursing practice is being called upon to transition to a perspective that addresses the increasing globalization of healthcare, there is limited research in this vital area. This is especially evident in the sparse number of qualitative studies on the healthcare immersion experiences of BSN nursing students and their perceptions thus necessitating the proposed study.

Chapter Two

Review of Relevant Literature

Introduction

The effects of globalization are impacting healthcare in general, and nursing education and practice, in particular. As a result, nursing educational endeavors that will help prepare future nurses to care for the rising numbers of culturally diverse patients as well as meet nursing education standards such as accreditation guidelines need to be examined. In addition, short-term global immersion experiences rooted in nursing educational settings are gaining popularity as a means of providing nursing students exposure to global healthcare concepts, practices, and settings where students potentially may gain an understanding of caring for diverse client populations as well as diverse healthcare systems. The combination of these two broad areas, nursing educational endeavors and influences of global immersion experiences on nurses and nursing students is of primary interest and will be the main focus of the literature review. However, there is value in exploring global educational activities in other practice areas as well. Much can be learned from the successes and challenges faced in other programs that potentially could be incorporated into nursing educational global health endeavors. Therefore, the review of the literature will begin with an overview of the literature from non nursing educational programs and practice areas, followed by a more in-depth review of nursing educational endeavors and global healthcare immersion experiences. A summary of gaps in previous research lending support for this study is provided at the end of this chapter.

Overview of Literature Pertaining to Non Nursing Programs and Practice Areas

Although it was expected to find literature regarding immersion experiences from the field of anthropology, it was surprising to find literature pertaining to international education

from the library sciences. Other than anthropology, global immersion programs were found most often in teacher education as well as in business and marketing literature. Results in general provide evidence that a diversity of educational programs other than nursing and healthcare are utilizing global immersion programs in their practice areas to transform learning, particularly from a global and cultural awareness perspective. Experiential learning concepts utilized as a means of engaging students was found in much of the literature.

Search terms primarily included the following: global, globalization, immersion experiences, international education, student exchanges, and study abroad. Electronic databases such as Academic Search Complete; Business Source Complete; CINAHL; Education Research Complete; EJS E-Journals; Library, Information Science, and Technology Abstracts (LISTA), MLA International Bibliography; PsycARTICLES; PsycINFO; and SocINDEX were searched. Journal articles were taken from a variety of disciplines including anthropology, business and marketing, foreign language teachers, library science, social work, and teacher education. A variety of articles pertinent to the study were incorporated into the review in order to gain perspective on the topic of interest in the non nursing program areas. Literature reviewed included a mixture of anecdotal accounts, instructional/programmatic case examples, and research studies.

Anthropology

Several non-research based articles from anthropological literature were reviewed and focused chiefly on practical or applied application. Kinsella (2010) and Patch and Allen (2010) both discussed the uses and benefits of qualitative research methods such as ethnographic fieldwork and participant observation in creating transformative learning experiences for students while studying abroad. Kinsella (2010) addressed how teaching study-abroad students

the discipline of reflective note taking/journaling, a key element in ethnographic research and experiential learning, supported student learning, provided a foundation or anchor during the immersion experience, and increased cultural awareness that further contributed to relationship building opportunities with the host culture. Patch and Allen (2010) combined anthropological methods such as participant observation and fieldwork with transformative learning techniques such as active engagement (e.g., with the community abroad) to stimulate student growth in cultural competence. Three distinct program components were addressed including a pre-departure type of orientation, a field orientation, and the actual immersion experience (Patch & Allen, 2010). Finally, Smith (2010) discussed effective approaches to immersion experiences abroad. Ideas for preparation and training (e.g., reading lists, course syllabus, and language classes) were included and began approximately one year ahead of the experience. Preparation for the cultural immersion or interface included pre-immersion meetings with current and former students, language skill acquisition while abroad generally gained from living with a host family, and detailed organization of the experience all of which helped reduce culture shock (Smith, 2010). In addition, incorporating time for students to relax and reflect during the experience was helpful during their time abroad. A variety of debriefing methods was utilized in the post-immersion experience such as individual and/or group meetings and formal and informal opportunities to share insight and learning were included (Smith, 2010).

Education

A number of articles pertaining to education in general were reviewed. Articles included an essay (Wang, Peng, Pearson, & Hubbell, 2011), programmatic reflections (Stachowski & Sparks, 2007), anecdotal perceptions for curriculum (Rodriguez, 2011), and two research studies: a quantitative study aimed at understanding student choice/intent to study abroad

(Salisbury, Umbach, Paulsen, & Pascarella, 2009) and a qualitative study on pre-service teachers' perceptions of a short-term immersion program (Barkhuizen & Feryok, 2006). Wang et al. (2011) discussed the idea of study abroad/immersion programs for faculty versus students noting the lack of such programs for faculty members. The premise of such programs would be comparable to immersion experiences for students with the exception that faculty would have the opportunity to "...examine curricula and pedagogical practices" (Wang et al., 2011, p. 2) and be part of a cohort. Programmatic activities and phases of learning were identified during the cultural interface (e.g., effective teaching/learning techniques), the development of the learning community (e.g., peer review of teaching), and scholarly engagement (e.g., course design, curriculum changes) all within the context of an immersion experience.

Study abroad program perceptions also were reviewed. Stachowski and Sparks (2007) included reflections from 30 years of student teaching projects abroad similar to the information reported in Smith's (2010) article on immersion experiences. The primary exception is that Stachowski and Sparks (2007) have a long-running collaborative relationship with a foundation that provides support for their students' study abroad experiences. Rodriguez (2011) discussed the importance of designing/redesigning undergraduate teacher education curriculum to incorporate study abroad experiences as a means to increase cultural sensitivity in this practice area. Among the key ideas suggested for a redesigned curriculum was the inclusion of pedagogical practices, concerns related to language, social phenomena, as well as educational history and literacy issues.

Salisbury et al.'s (2009) quantitative study examined the impact of a variety of factors (e.g., financial, social, and cultural) on students' intent to study abroad. An integrated model of college choice was utilized in the study of 2,772 college freshman. The primary hypothesis was

that socio-economic and cultural capital accumulated prior to college influenced students' choice to travel abroad (Salisbury et al., 2009). Logistic regression analysis was used to analyze the data. Demographic characteristics that positively influenced choice to study abroad included higher family income and parents' educational level, white ethnicity, female gender, openness to diversity, and attendance at liberal arts colleges. Variables of significance were students' interactions with a diversity of people and co-curricular involvement.

The Barkhuizen and Feryok (2006) qualitative study focused on post-graduate diploma in education students' perceptions of a short-term immersion program through evaluation of pre- and post-immersion questionnaires as well as student reflective journals. Seven themes were identified including the following: (a) New Zealand culture, (b) the environment, (c) language development, (d) pedagogical understanding, (e) the academic program, (f) interpersonal awareness, and (g) personal growth (Barkhuizen & Feryok, 2006). Recognition that every participant will view the program differently led to the importance of thorough preparation in the pre-immersion phase. Furthermore, teamwork and communication at every level at home and abroad was cited as a critical element along with opportunities to build relationships with locals in the host country.

Business and Marketing

Recent articles from business and marketing primarily included research studies. McKenzie, Lopez, and Bowes (2010) provided guidance for regional and small universities in planning immersion experiences primarily because of the increased focus on such programs as well as the rising numbers of students participating in study abroad programs (e.g., 242,000 students in 2008). McKenzie et al. (2010) spoke of the benefits of small/regional universities designing their own programs instead of joining other, pre-established programs, and potentially

losing control of course design, income from tuition, and faculty development opportunities.

Key areas to consider when developing a study abroad program included evaluating the suitability of faculty involved in the program, selection of the immersion location including its' appeal to students, course content design that balances academic and non academic experiences, as well as post-immersion reflection and appraisal (McKenzie et al., 2010).

A qualitative study utilizing consumer ethnography and hermeneutic data analysis examined students' perceptions by using student information from University-approved graffiti bricks and interviews (Wright & Larsen, 2012). Travel trophies on the wall, magic moments, community, and academics were the identified themes. Findings included the importance of having a mechanism for students to influence the experience and/or the design of it; program and student-directed travel opportunities; housing arrangements to enhance social interaction of participants; faculty interested in the experience that were personable, but also able to provide appropriate discipline; and meaningful learning experiences from an academic perspective. Wright and Clarke's (2010) mixed-method study empirically explored student observations about a study abroad program (SAP) gathered from pre- and post-immersion surveys. Significant differences were found for cultural pluralism, interconnectedness, and efficacy as well as for adaptation and intercultural communication. Qualitative findings supported quantitative results.

The goal of Gullekson's (2011) quasi-experimental study using a convenience sample ($N = 104$) was to evaluate whether or not the study abroad program was meeting its' objectives to provide opportunities to increase students' cultural sensitivity and appreciation of other cultures. Pre- and post-test measures were completed on participants. Significant results were found with a number of variables (e.g., time, group, time-group interaction, ethnocentrism, intercultural

communication, and intercultural awareness) between the pre-and post-test measures for the treatment group. It was suggested that the pre- and post-test changes needed further evaluation and that interpretation of the results was not clear even though the study findings supported the benefits (e.g., psychological) of students participating in the immersion portion of the study. Loh, Steagall, Gallo, and Michelman (2011) also examined the value of an SAP utilizing a contingent valuation (CV) method to determine the amount of money students would be willing to pay for a short- or long-term immersion experience. This was deemed important to business majors in particular because the cost of an immersion experience was often more than the cost of a regular semester at the University. Pre- and post-immersion multiple-bounded dichotomous choice surveys were utilized to gather data on students' assessed value of the SAP in variety of areas (e.g., job market prospects, personal growth, cultural understanding, and foreign language skill). Significant findings were found with three variables: (a) enhanced job market prospects, (b) learning about family heritage, and (c) practice foreign language skill. One interesting finding pertained to students' perceptions about culture shock which were underestimated in the pre-immersion experience and were more significant post-immersion. The authors recommended that program facilitators find ways to prepare students to deal with culture shock, particularly in the post-immersion or re-entry phase of a study abroad experience.

Foreign Language Teachers, Social Work, Library Science, and Psychology

A sampling of articles from foreign language teacher literature, social work, and library science is included in this section. Research articles and programmatic guidelines were the main types of articles reviewed. In addition, a key article from the area of psychology synthesizing a review of the literature on culture shock is incorporated into this section because of its relevance to the topic (Furnham, 2010).

A qualitative study related to language teachers (Allen, 2010) and a mixed-method study pertaining to students (Cadd, 2012) in immersion programs were reviewed from the discipline of foreign language acquisition. Allen's (2010) research evaluated the impact of a SAP on world language (WL) teachers because of the limited research in this area. Thirty teachers, chiefly female, participated in the study. The selection process was guided by participants' teaching commitment, intellectual curiosity, cultural interest, and level of proficiency of the host country's language. Four themes emerged from the data: (a) increase in French proficiency, (b) growth in cultural knowledge, (c) changes in curriculum and/or instructional practices, and (d) impact on professional lives outside the classroom supporting the overall goals of the program. On the other hand, Cadd's (2012) research focused on specific functional tasks (e.g., asking directions) requiring language proficiency taken on by 13 students participating in a SAP. Post-immersion survey responses (e.g., Likert items) were used for the quantitative portion of the study whereas analysis of comments was done for the qualitative portion. In general, qualitative data supported quantitative findings. More specifically, completion of the functional tasks decreased anxiety/nervousness and boosted students' confidence to interact with native speakers as well as their fluency in the host country language.

Articles related to social work provided practical information about a model for developing a study abroad program (Mathiesen & Lager, 2007), principles of effective field placement (Lough, 2009), and pedagogical practices in international study abroad courses (Roholt & Fisher, 2013). Mathiesen and Lager (2007) identified key components for a study abroad program including feedback loops and a focused overview with program stakeholders; orientation; identification of gains, costs, and expectations; and establishment of roles for all involved at home and abroad. A review of pertinent theoretical and empirical literature

regarding the positives and negatives of immersion programs was provided in Lough's (2009) article. A summary of results was presented. Suggestions for designing a study abroad program were offered and included an emphasis on meaningful student placements abroad, proper support in each phase of the experience (pre-immersion, cultural interface, and post-immersion), incorporation of reflective and experiential activities, consideration of the length of the program (longer programs support long-term changes), and reciprocity with both the sending and receiving organizations (Lough, 2009). Roholt and Fisher (2013) discussed pedagogical best practices for building students' cultural skills and understanding in an international immersion program citing that exposure to the experience is only half of the equation. Careful consideration should be given to length of stay, structured learning, reflective dialogue, active engagement, as well as faculty modeling how to process key learning moments when developing international study abroad experiences.

Both articles reviewed from library sciences addressed the importance of supporting study abroad students and faculty through digital libraries chiefly because of the increase in study abroad programs over the past two decades in multiple educational programs. Wang and Tremblay's (2009) article centered more on one University's experience in customizing library services particularly for educational locations abroad. Components considered most essential for providing library services abroad included physical location and conditions, the computing environment in terms of numbers and availability of equipment, local access to libraries as well as having a designated link for global studies on the library's main website and accessibility of e-books, Interlibrary loans, online tutorials and chat options, and bilingual web pages. Kutner (2010) provided information on the development of a model for a distinct study abroad program in Central America. Essential factors for this program included many of the same components

identified in Wang and Tremblay's (2009) article but also included the importance of working collaboratively with host-country universities and educational institutions. Availability of locally relevant data and research through digital library resources was determined to be an added benefit to the host country.

The final article reviewed in this section of non nursing literature comes from the discipline of psychology. Furnham (2010) synthesized the pertinent literature in a review about culture shock. Literature on commonly used definitions, symptoms (physical and social reactions), and psychometric tools and model testing related to culture shock was examined. Pertinent research regarding foreign students and student exchanges also was included along with key information about homesickness, and student adaptation. At present, no grand theories have emerged from the literature to help explain the phenomenon of culture shock and cultural adjustment. However, various patterns of what is known are beginning to emerge and include the following: foreign students tend to experience more academic issues than local students; concepts such as the culture-distance concept (e.g., where the amount of difference and/or distance between one's own culture and the host country is relative to the stress experienced) are being utilized to predict traveler stress; and consideration of psychological research to evaluate cultural adjustment is in process. Although the article was written with respect to the South Pacific, it has relevance for this study.

Overview of Literature Pertaining to Nursing Education

Key educational endeavors that directly or indirectly affect nursing are initially reviewed and include information from several sources. A discussion about teaching/learning strategies important to nursing education will follow. Specifically, information pertaining to teaching/learning pedagogies including principles of adult learning theories, experiential/situated

learning, best practices for student engagement, significant or transformational learning, and education for intercultural experiences will be covered.

Search terms primarily included the following: student engagement, engaging students, academic achievement, learning environment, learning strategies, experiential learning, active learning, interactive instruction, learning styles, significant learning, and transformational learning. Electronic databases such as Academic Search Complete, Business Source Complete, CINAHL, Education Research Complete, EJS E-Journals, PsycARTICLES, PsycINFO, and SocINDEX were searched. Journal articles were taken from a variety of disciplines including, but not limited to nursing, physical therapy, education, and psychology. Literature reviewed included a mixture of anecdotal accounts, case examples, philosophical/theoretical reviews, and qualitative and quantitative studies. In addition, excerpts from several books relevant to nursing education were included in the review of the literature. Experiential learning theory concepts were found in much of the literature. Results in general provide evidence that faculty behaviors, instructional design, and experiential learning are important for engaging students in the learning process.

Organizations and Projects Influencing Nursing Education and Practice

This section will begin with a review of key organizations and/or projects that directly or indirectly influence nursing education and practice. The Institute of Medicine (IOM, 2013), that is the National Academy of Sciences (NAS) primary adviser on improving the health of the nation to those in the government and private sector, is one such organization whose work offers support for innovative changes in nursing education and practice. Two landmark reports of importance to this study are discussed below.

Institute of Medicine. In 2001, the Institute of Medicine (IOM, 2001) aptly assessed the quality of the 21st century health care system as a chasm. Advances in medical science, the increased complexity of the health care system, and changes in the public's health care needs as evidenced by rising numbers of chronic illnesses and shifting demographics, were cited as contributing factors creating this gap (IOM, 2001). Aims for improvement in the health care system were recommended and focused on timely, safe, effective, efficient, equitable, and client-centered care (IOM, 2001). General guidelines for a redesigned system (e.g., evidence-based practice, use of informatics, relationship-centered care, and shared knowledge among healthcare providers) also were included but minimally defined to allow for maximum innovation for those involved in the delivery of health care (IOM, 2001). An adequately prepared work force was stressed as a key component to the long-term success of recommended changes (IOM, 2001). Further emphasis of the need for health care workers to be well-trained and prepared in order to provide quality and culturally-sensitive care, is of significance specifically related to changing ethnic and racial demographics in the United States, also can be found in the literature (Giger et al., 2007; Howarth et al., 2006; Huston, 2008; Mak, Watson, & Hadden, 2011; Wells, 2000).

With the recent passage of the Affordable Care Act (ACA), a collection of legislative changes designed to provide health insurance to millions of Americans currently without coverage, alterations in the current health care system will be inevitable (IOM, 2011). Along with this, the Institute of Medicine and the Robert Wood Johnson Foundation, an organization committed to ensuring a skilled and competent nursing workforce, partnered together to evaluate the capability of the nursing profession to meet these challenges (IOM, 2011). Implications of these changes resulting from the passage of this law are expected to have a dramatic effect not only on efforts to redesign the health care system, but more importantly, on how nurses, the

largest group of health care providers, potentially will meet the challenges (IOM, 2011). The report is broadly structured around four main points, one of which discusses implications for all levels of nursing education as well as the need for new competencies in practice settings (IOM, 2011). Moreover, support for lifelong learning and leadership opportunities for nurses and nursing students, as a means to better care for culturally- and ethnically-diverse patients also were made (IOM, 2011). In conjunction with this, recommendations for the addition of global health care concepts into nursing curricula were presented (IOM, 2011). The significance of the findings presented in this report to nursing education cannot be overemphasized.

Nursing education and accreditation organizations. The National League for Nursing (NLN), established near the turn of the 20th century, has focused primarily on excellence and quality in nursing education for all nursing program types (NLN, 2013b). The NLN's mission, goals, and objectives clearly identify and support the need for a well-prepared workforce to meet the demands of the nation's evolving health needs (NLN, 2013c). The NLN specifically has called for reform in nursing educational systems that will be innovative, flexible, evidence-based, and responsive to the needs of learners, healthcare clients, accrediting bodies, and communities of interest (NLN, 2003). Moreover, the challenge to think of bold, new ideas that are significant and innovative remains and is supported in the nursing literature as well as through the endeavors of organizations such as the Institute of Medicine (Benner, Sutphen, Leonard, & Day, 2010; Gatzke & Ransom, 2001; IOM, 2001; 2011; Ironside, 2005). In addition, the NLNAC, the independently functioning accrediting body for the NLN, monitors and supports improvement in nursing educational endeavors through the accreditation process (NLNAC, 2013). A joint NLN/NLNAC global task force recently has been established with the goal of

providing leadership related to faculty development, quality nursing education, accreditation issues, and nursing research related to education from a global perspective (NLN, 2013a).

The American Association of Colleges of Nurses (AACN) also works to support excellence in nursing education, specifically for baccalaureate and graduate education rather than for all levels of programs (AACN, 2013a). The AACN's mission, values, and goals although different, have similarity to those of the NLN (AACN, 2013c). Of particular interest to this study is the document containing standards and guidelines established for baccalaureate nursing education (AACN, 2008). Recommendations from stakeholders and key documents such as the aforementioned IOM reports are outlined in the standards; focus on educational efforts of nurses; and includes concepts such as client-centered care, cultural sensitivity, evidence-based practice, and quality improvement and safety (AACN, 2008). Special attention related to the increasing diversity in the health of the U.S. population, as well as the effects of globalization are given with these guidelines (AACN, 2008). Furthermore, the need for professional nurses to possess the skills and competencies to provide culturally-congruent care is addressed (AACN, 2008). A variety of publications pertaining cultural competency in nursing are available for nurse educators (AACN, 2013d). The Commission on Collegiate Nursing Education is the independent entity that provides and monitors nursing educational endeavors similar to the functions of the NLNAC (AACN, 2013b; Commission on Collegiate Nursing Education, 2009; NLNAC, 2013).

Quality and Safety Education for Nurses (QSEN) Institute. The Quality and Safety Education for Nurses project was initiated as a means to help nursing educational institutions prepare future nurses to function effectively within the evolving healthcare system (Quality and Safety Education for Nurses [QSEN] Institute, 2013a). The primary focus of this endeavor was

to identify the knowledge, skills, and attitudes (KSAs) nurses need in order to practice safely and with excellence (QSEN Institute, 2013b). QSEN competencies include teamwork and collaboration, client-centered care, practice that is evidence-based, quality improvement, safety, and informatics (QSEN Institute, 2013b) and follow closely with the recommended changes for the health care delivery system (IOM, 2001; 2011) and in nursing education and practice, as outlined above by the NLN (2003, 2013c) and the AACN (2008). Although the QSEN project has recently been updated to the QSEN Institute, educational materials and teaching strategies are still available for nurse educators (QSEN Institute, 2013c). Updated information on the knowledge, skills, and attitudes (KSAs) needed in pre-licensure nursing programs has been added along with KSAs important for graduate students (QSEN Institute, 2013d).

Nursing Education and Practice Theories

The nation's call for sweeping changes in the health care system, including delivery of care (IOM, 2001) is being answered through a variety of initiatives such as the QSEN project (QSEN Institute, 2013a), yet the challenge of radically transforming the quality of nursing education and practice remains (Benner et al., 2010; NLN, 2003; 2013c). Instead of rearranged curricular designs and processes, the demand for excellence and innovative changes in nursing education and practice requires strategies based in sound pedagogical research that will meet the recommendations for change as described above (AACN, 2008; IOM, 2011; NLN, 2003; QSEN Institute, 2013b).

The pedagogy/andragogy dichotomy. Regardless of the setting, nursing educators need to be knowledgeable and skilled in implementing a variety of teaching/learning methods, in order for education to be most effective (Benner et al., 2010; Ironside, 2005). In order to have a better

understanding of teaching/learning methods, a general review of the literature related to components in the pedagogy/andragogy dichotomy is necessary.

The composite word pedagogy has a literal correspondence to the education of children and youth, and has been considered to be archaic, non-dynamic, amateurish, and misused (Forrest & Peterson, 2006; Knowles, 1976; Mohring, 1990). These designations cast a negative view of pedagogy, giving rise to the belief among educators that it involves specific teaching methods that are deemed as passive and inappropriate for today's learners (Forrest & Peterson, 2006). Despite this description, pedagogy is more generally described as the art and science of teaching (Merriam-Webster Online Dictionary, 2013d). Andragogy, on the other hand, has been presented as the study of adult learning methods. Contemporary use of this term came out of Malcolm Knowles' work in the 1970s (Forrest & Peterson, 2006; Knowles, 1979; Mohring, 1990; Russell, 2006). Knowles' (1979) early experiences working in training and development of adults led him to theorize about adult learning. Six assumptions about adult learners have been described and include the following: (a) they are self-directed, (b) they have a wealth of experience and knowledge, (c) they are ready to learn, (d) they are intrinsically motivated to learn, (e) they are oriented for immediate application of knowledge, and (f) they have a need to understand the rationale for learning (Forrest & Peterson, 2006; Russell, 2006). It is noteworthy that changing demographics in the USA over the past 30 years has altered the formerly homogeneous population of adult learners to a much more socially and culturally diverse group of learners whose learning styles and needs are different than the traditional adult learner (Marschall & Davis, 2012).

Forrest and Peterson (2006) suggest that neither pedagogy nor andragogy are teaching techniques, but instead, they provide philosophical guidance for educators. Furthermore, the

phrase instructional strategy is not viewed as either pedagogical or andragogical, but as the method for how information is presented to learners (Forrest & Peterson, 2006). Finally, utilization of pedagogical strategies will differ from andragogical approaches to education and instructional strategy (Forrest & Peterson, 2006).

Learning styles, experiential learning, and situated learning. Traditional learning styles (e.g., visual, auditory, and kinesthetic) are included in this discussion because of their relationship to experiential learning. In brief, visual learners need mental images to help them understand ideas better, whereas auditory learners have a preference for hearing instruction and/or entering into dialogue with someone. Kinesthetic learners do better when able to practice skills through hands-on activities (Russell, 2006). Kolb's (Kolb & Kolb, 2005) experiential learning theory (ELT) incorporates components from the traditional learning styles and introduces the concept of learning spaces or the environment where learning takes place. Sandlin, Wright, and Clark's (2013) article supports the idea of learning spaces and suggest that most learning does not take place in formal educational settings, but in more informal settings such as public places (e.g., from museums to movie theatres). However, the crux of Kolb's theory is that how people learn influences and shapes their development (Kolb & Kolb, 2005).

Experiential learning is considered more of a philosophy of education than a tool kit for educators primarily because learning is viewed as a process that should engage students (Kolb & Kolb, 2005). For these reasons, it is frequently utilized for adult learners (Miettinen, 2000). Experiential learning also has been considered beneficial in a multitude of academic disciplines as noted by Rosenstein, Sweeney, and Gupta (2012) from their survey of cross disciplinary faculty and as evidenced in the literature pertaining to anthropology (Kinsella, 2010; Smith, 2010), teacher education, (Wang et al., 2011), business and marketing, (Gullekson, 2011; Wright

& Larsen, 2012) and social work (Lough, 2009; Roholt & Fischer, 2013). The primary components of the experiential learning theory include a concrete experience (specific tasks), reflective observation (thinking), abstract conceptualization (theory), and active experimentation (practice) where the learner is moved through the cycle of learning through use of multiple ways to enhance the learning experience (Kolb & Kolb, 2005). The experiential learning theory has been utilized successfully as a model for continuing education of nurses (Russell, 2006; Sewchuk, 2005), in research to examine ways to more actively engage students in learning difficult topics such as nursing research methodologies (Pugsley & Clayton, 2003), and in nursing theory in an effort to present materials in a more creatively in an online learning course (Levitt & Adelman, 2010).

Benner et al. (2010) discusses the idea of experiential learning in nursing education that also is situated in a variety of clinical practice settings. For example, the hands-on experiences students have from taking care of their patients is experiential in nature, but also provides learning situated in a clinical setting (Benner et al., 2010). In situated learning, the relationship between learning and the social environment in which it occurs is critical (Lave & Wenger, 1991). In addition, the learner must be actively engaged in the process of learning in a situated context (Lave & Wenger, 1991). Furthermore, legitimate peripheral participation is a key concept of situated learning that requires novices or beginners to progress toward participating fully in the community of learners in order to master the necessary knowledge and skills (Lave & Wenger, 1991). The combination of these two concepts is central to nursing education (Benner et al., 2010).

An example from the literature includes use of a situated pedagogy in student placements in practice settings at the completion of their nursing educational programs (Cope, Cuthbertson,

& Stoddart, 2000). Analysis of the students' experiences was done resulting in three themes emerging from the data that included the following: (a) students were beginning to be incorporated into the community of practice, (b) contextualization of the learning process was cyclical, and (c) support of learning in practices was modeled by mentors and appropriately withdrawn as students gained skill and expertise in practice (Cope et al., 2000). In addition, students understood the importance of placements as being part of the social context of joining the community of nursing professionals (Cope et al., 2000).

Significant learning experiences and student engagement. In this seminal work, Fink (2003), discussed the idea of how a taxonomy of significant learning experiences is critical to quality in higher education. This is particularly true because of fundamental institutional changes that are taking place such as the influx of information technology, new kinds of educational providers, globalization of educational endeavors, and as a result of these changes, different types of students (Fink, 2003). Teaching/learning paradigms that include the purpose of learning, criteria for success, learning structures and theories, as well as the role of the faculty, also are changing (Fink, 2003).

The taxonomy of significant learning as described by Fink (2003) has six major categories: (a) foundational or basic knowledge necessary for other types of learning, (b) application learning where the student is actively engaged, (c) the process of making connections or integrating knowledge, (d) the capacity of the human dimension to interact and therefore function more efficiently in the learning process, (e) the ability to care about learning, and (f) the process of learning how to be a self-directed and lifelong learner. Fink (2003) stresses the importance of integrating quality into the design of the course by developing course goals, evaluation and feedback measures, and teaching/learning activities that specifically involve

students in the process of doing and/or reflecting, both of which are components of active learning. Furthermore, if students are actively engaged in the learning process, a reasonable expectation is that the results or outcomes of learning will be long-lasting. In addition, incorporation of significant learning experiences allows educators to envision greater possibilities for student learning as noted in the exemplars provided from a variety of teaching/learning situations found in Fink and Fink (2009).

The concept of active engagement was further examined in the literature. Findings from the literature focused primarily on the concepts of experiential learning and described positive effects of experiential learning on student attitudes, levels of appreciation, and academic outcomes (Gatzke & Ransom, 2001; Popkess & McDaniel, 2011; Pugsley & Clayton, 2003; Salamonson, Andrew, & Everett, 2009). For example, an experiential, interactive model in a nursing course was utilized to determine whether or not this would affect student attitudes (Pugsley & Clayton, 2003). Results from evaluations indicated that students participating in a course with an experiential focus had more positive attitudes than their counterparts (Pugsley & Clayton, 2003). In an effort to engage students in more active learning, an experiential model was utilized in several other case examples that included a review with student evaluations; this also validated the positive effects of the change (Gatzke & Ransom, 2001; Jacobson & Goheen, 2006; Sewchuk, 2005). Active engagement also was examined in relation to positive academic achievement (Popkess & McDaniel, 2011; Salamonson et al., 2009).

Alienation or disengagement, as opposed to engagement, is a growing concern in higher education that can occur when students do not fully engage in the learning process (Mann, 2001; Salamonson et al., 2009). Examples of alienation include rote learning or learning done solely to meet the course requirements as well as issues of respect and authenticity in the

teaching/learning environment, long-term value and/or relevance of the topic being learned, and academic distracters such as part- or full-time employment status (Horstmanshof & Zimitat, 2007; Kolb & Kolb, 2005; Mann, 2001; Salamonson et al., 2009). Salamonson et al. (2009) utilized a prospective survey design in their evaluation of 153 nursing students enrolled in a pathophysiology course. The purpose of the study was to compare academic engagement to the demographic characteristics of ethnicity, age, and employment (e.g., part-time work). Results indicated that academic engagement activities such as class attendance and completion of assignments was positively associated with students' academic achievement whereas time spent working (at least 16 hours per week) had a negative, but significant affect on academic performance.

Sellheim's (2006) study examined the relationship between faculty beliefs (which can affect the teaching/learning environment) and preferred methods of instruction (e.g., experiential learning). Results indicated that faculty understood their role as a facilitator of learning (in theory), yet had difficulty assimilating this knowledge into practice primarily related to time constraints in the classroom (Sellheim, 2006). In Umbach and Wawrynski's (2005) study, faculty behaviors (e.g., interaction) were found to have an impact on student engagement related to the learning culture created by faculty. Moreover, the quality of engagement students had with faculty differed in four areas: (a) the level of active commitment presented by the teacher, (b) the perceived permeability (boundaries) of the classroom, (c) norms and expectations for students that were set by the faculty, and (d) faculty assumptions about students (McMahon & Portelli, 2004; Patrick & Middleton, 2002). In addition, the environmental features (e.g., placement of windows, lighting, and arrangement of desks) of the classroom were found to effect instructional design of courses, student participation, and learning efforts (vanGrinsven &

Tillema, 2006). Finally, Sandlin et al. (2013) provided perspective on active learning from the public environment such as museums, movie theatres, and radio, for example.

Education for global immersion experiences. Resources specifically addressing educational needs for immersion experiences in general were difficult to obtain. However, one classic resource for intercultural education (Paige, 1993a) was reviewed and is briefly discussed below. Although this information also pertains to the discussion on global healthcare immersion experiences, it is purposely placed in this section because of its educational focus. Contributing authors addressed a variety of topics in this resource including general information about intercultural learning, cultural sensitivity and awareness, training goals, characteristics of trainers and trainees, and methods for adjusting to cultural stress during the immersion experience, as well as in the post-immersion time.

It is worth noting that the nature and intensity of a global immersion experience calls for specialized instruction that is steeped in methodologies responsive to the needs of transcultural learners but which also meets the demands of the learning experience (Paige, 1993b). This type of learning is by necessity different than conventional educational endeavors. For example, the immersion experience by itself is typically comprised of intense emotions (e.g., disorientation that can occur in culture shock) and the way people think and assess information can be difficult to understand based on cultural differences (Paige, 1993b). In addition, learners are pushed to reflect on situations often without firsthand experience and are required to utilize alternative ways of knowing and learning in order to function effectively in an immersion situation (Paige, 1993b). Furthermore, key characteristics of an intercultural learning experience that were discussed in this well-known resource that is frequently cited included concepts from Kolb's (Kolb & Kolb, 2005) experiential learning theory such as reflection and active participation,

relationship-centered orientation, and use of assimilation in the preparation phase with a focus on skill development (Juffer, 1993; McCaffery, 1993). Finally, careful planning is needed for participants in the often neglected reentry phase in order to assist them in the process of understanding their immersion experiences (LaBrack, 1993).

In addition, another resource related to global service learning in nursing was reviewed for its detailed information on program development (McKinnon & Fitzpatrick, 2011). McKinnon and Fitzpatrick (2011) gathered and compiled information and resources for global service learning opportunities. Examples of topics included in the book are as follows: core principles for developing global nursing programs, applicable theoretical frameworks, administrative roles and responsibilities at home and abroad, best practices, building partnerships for study abroad, as well as resources for global health endeavors.

Overview of Literature Pertaining to Global Healthcare Immersion Experiences

Influences of global healthcare immersion experiences are categorized into two areas: (a) anecdotal/descriptive accounts that were further subdivided into information related to general global health programs, educational programs focused on global health, and immersion experience outcomes; and (b) research-based studies subdivided into literature reviews, articles centered on enhancement of cultural competence, model development, and both short-term and long-term outcomes. The aim of the second portion of the review is to present a synthesis of current findings in the literature: (a) on how global healthcare immersion experiences may benefit nurses and nursing students by supporting enhanced learning of cultural understanding and global healthcare leadership skills, (b) on how educational programs incorporating global healthcare immersion experiences support learning in areas related to global awareness and cultural understanding, and (c) to identify future research needed specifically on the experiences

of BSN students in global healthcare immersion programs provided through an academic offering.

The following electronic databases were searched for literature related to global healthcare immersion experiences: Academic Search Complete, ATLA Religion Database, ATLA Religion Database with ATLASerials, CINAHL, Education Research Complete, E-Journals, MEDLINE, PubMed, PsycINFO, and SocINDEX. Keywords and phrases used in the search included: international education, study abroad, international exchange, international partnership, mission trip, medical missions, cross-cultural experience, global health, nursing education, nurses, transcultural nursing, and international health experience. A variety of articles were incorporated into the review in order to gain perspective on the topic of interest.

Journal articles were primarily taken from nursing literature and ranged in years from the mid-1990s to 2012. Much of the literature reviewed focused on a wide variety of educational and clinical practice programs designed to support nursing students' cultural learning, increase cultural sensitivity and competence as well as provide cultural encounters, such as with a global healthcare immersion experience. These educational and practice endeavors have been presented largely in anecdotal/descriptive accounts or through research efforts. Therefore, synthesis of findings will be divided to include anecdotal/descriptive information followed by pertinent research studies.

Anecdotal/Descriptive Findings

Although the information in this section is not research based, it nonetheless provides understanding of how nurses increasingly are involved in globally-focused endeavors, many of which have been developed in response to the myriad of healthcare challenges created by globalization (Huston, 2008). In turn, this points to the need for healthcare workers, specifically

nurses, to be culturally competence, a desired trait/attribute for all healthcare providers (Giger et al., 2007; Wells, 2000). Furthermore, training and education is necessary along with opportunities for nurses to practice their cultural skills through caring for members of the global community. Findings are generally divided into several categories that include general global health programs, educational programs with a global focus, and immersion experience outcomes.

General global health programs. Overall, healthcare providers have begun addressing the health challenges related to globalization. Verification of these efforts is demonstrated through the myriad of ongoing health programs and projects such as those sponsored by the World Health Organization (2013a). Specifically, nurses are actively involved in targeting global healthcare issues as evidenced by recent efforts found in the literature including, but not limited to the following: (a) international guidelines for migration of nurses (International Council of Nurses, 2007), (b) global health assemblies involving key nursing leaders that are designed to develop strategies for sustainable workforces worldwide (Swenson et al., 2005), (c) grass-roots telehealth clinics in underdeveloped areas such as in Cambodia (Lugn, 2006), and (d) plans for improved health outcomes for diverse patient populations (Giger et al., 2007; Hegyvary, 2004).

Educational programs focused on global health. Moreover, a wide variety of educational programs designed to enhance nurses' understanding of global healthcare issues was found in the literature. Expanding and/or revising nursing coursework to include classes specific to global healthcare concepts is one way that this is occurring (Peate, 2008; White, 2005). Another avenue is the development of guidelines for international continuing education programs with the purpose of enhancing participant understanding of healthcare issues in the host country (DiFazio, Boykova, & Driever, 2009). According to DiFazio et al. (2009), nurses

participating in these continuing educational endeavors have an opportunity to increase levels of cultural competence as well as gain perspective related to similarities and differences in nursing practice and education with nurses in the host country. In addition, aspects of international education are being examined as noted by the creation of accreditation standards expressly for these types of educational offerings (NLNAC, 2010). Likewise the International Council of Nursing is helping to determine and confirm global trends that support the development of advanced nursing practice and education in global health settings (Sheer & Wong, 2008). Transformative learning opportunities are occurring during educational exchange programs as well (Foronda & Belknap, 2012; Hu, Andreatta, Yu, & Li, 2010). Finally, the idea of promoting cultural safety as a tool to transforming nursing education through enhanced clinical reasoning skills has been explored through study abroad options (Mkandawire-Valhmu & Doering, 2012).

The detailed descriptions of programs centered on international educational experiences, often termed partnerships or exchanges that are used synonymously, were easily found in the literature. Although no clear definition for the above-mentioned terms was found, Mason and Anderson (2007) provides a well-articulated philosophy that: (a) a partnership should be mutually beneficial to both countries, (b) all participants should take on the roles of teacher and learner within the context of the exchange, (c) a spirit of cooperation among all persons and facilities involved should be present, and (d) the partnerships should be multifaceted in that they are both educational as well as support enhancement of healthcare practices in both countries. These philosophical elements were present in part or in whole in the descriptive accounts reviewed. For example, in Kuehn et al.'s (2005) descriptive account, issues such as partnership and development of the educational component were addressed along with venues for effective communication and personal characteristics important to the success of a global health exchange.

Bosworth et al. (2006) focused more exclusively on the educational and healthcare practice components. Also of note, was that partnerships were generally based on previously established connections between persons or institutions with the countries involved in the exchange, and most often took place in resource poor areas (Heck, 2007).

Accreditation guidelines such as those provided by the American Association of Colleges of Nursing (2008) have prompted the development of international educational experiences or global healthcare immersion experiences particularly for nursing students as noted in several articles (Andreatta & Hu, 2010; Bosworth et al., 2006; Hu et al., 2010; Kuehn et al., 2005; Robinson, Sportsman, Eschiti, Bradshaw, & Bol, 2006). In another account, Hern, Vaughn, Mason, and Weitkamp (2005) describe a model of care that emerged from the partnership between hospitals in the USA and Scotland for the specific purpose of improving care given to pediatric patients and their families. Although not generated through research methods, this model resulted from practical experience gained from working with the partnership. The identified components of this model of care include a shared vision, workplace infrastructure development, sources of funding, program outcomes, marketing success, lessons learned, and ideas for future planning (Hern et al., 2005). In yet another example, Doyle (2004) utilized new science leadership theory in the development and implementation of an international exchange for nursing students. As part of Wheatley's (Wheatley, 1992; 2000) theory that suggests innovation lies with the construction of strong relationships, students and faculty involved in the exchange had the opportunity to examine and compare their personal leadership styles with the outcome goal of maintaining a more relationship-focused versus a task-oriented leadership style.

Immersion experience outcomes. Outcomes from the educational endeavors described above attest to personal and professional gain for participants. For example, participants

described appreciation of the knowledge and experience of healthcare providers in the country visited, enhanced cultural sensitivity and awareness (e.g., a broader global perspective), the development of a collaborative work relationship with the healthcare team, and transformational learning (Andreatta & Hu, 2010; Bosworth et al., 2006; Foronda & Belknap, 2012; Hu et al., 2010; Kuehn et al., 2005; Patterson, 2007; Pryor, 2006; Souers, 2007). It is important to note that collaboration occurred not only with the host country's healthcare workers, patients, and their families, but also among team members that traveled to the international location (Andreatta & Hu, 2010; Bosworth et al., 2006; Kuehn et al., 2005; Pryor, 2006). In addition, the ability to collaborate effectively within the global healthcare arena has been identified as important in the development of nursing leadership (Huston, 2008). Other benefits described in these accounts highlight the value of cultural experiences on professional practice as indicated by improved understanding of a healthcare system different than one's own, increased knowledge of health conditions and their outcomes and enhanced assessment skills, critical thinking, and problem-solving abilities learned through research and debriefing exercises (Andreatta & Hu, 2010; Bosworth et al., 2006; Patterson, 2007; Priest, 2007; Pryor, 2006; Souers, 2007).

Based on the above, it is apparent that professional practice and educational efforts are being made by nurses to address the healthcare needs related to the effects of globalization. There is evidence, albeit anecdotal and descriptive, that there are positive outcomes from the programs and educational endeavors described above. This information helps to establish a foundation of understanding related to global healthcare immersion experiences and is an important part of this review. However, findings from research-based studies are critical to this review and will be discussed in the following section.

Research Findings

For ease of review, synthesis of relevant literature is grouped together according to primary common threads embedded in the articles. Placement in one grouping does not negate its applicability to another category. Several reviews were found in the literature and will be placed under one heading. Although it could be argued that enhancement of cultural competence is considered to be a short- and long-term benefit of a global immersion experience, research that centered on development of cultural competence will comprise its own category. Another group will include studies focusing on the development of models and matrices. Finally, the last two groupings will cover the research reviewed that could be considered as short-term outcomes and long-term outcomes.

Literature reviews. Synthesis of literature relevant to global healthcare immersion experiences was done in two separate reviews (McAuliffe & Cohen, 2005; Button et al., 2005). The impetus for the first review (McAuliffe & Cohen, 2005) came from international conference objectives established to review achievements in global health research, set a future vision, and develop an agenda for health research for the next decade since international exchanges were deemed as one way to strengthen nursing care, education, and research efforts around the globe. Of the 79 articles reviewed, 89% were categorized as descriptive accounts of international exchange experiences that were written primarily from faculty perspectives. Whereas actual research studies incorporating mostly qualitative methods approximated 11% of the review and included description of faculty perceptions or impact of the experience on students. Future research recommendations were centered on critically appraising program outcomes as well as testing pertinent theoretical models that could be used as guides for global immersion experiences.

The growing number of culturally diverse patients and the subsequent need for culturally sensitive nurses led to the second review that explored relevant research studies on the personal and professional impact of global immersion experiences on nurses, examined methodological approaches, and identified differences in programs (Button et al., 2005). Search terms used for the review included keywords focused on international exchange experiences, combined with nurses and nursing, as well as education, practice, evaluation, and/or policy. Articles that were discarded included those without a defined methodology and/or lacked an educational focus such as articles describing immersion programs related to religious work. Forty-three research-based articles were reviewed for recurring themes that were identified as benefits of a global experience, differences in programs, and cross-cultural adjustment. The number of pertinent research studies was attributed to the recent introduction of educationally-focused global healthcare immersion experiences. Greater analysis of program assignments, long-term effects (e.g., cross cultural skills) of student participation in global healthcare immersion experiences, and adequate preparation of students by educational institutions were suggested as focus areas for future studies.

A third systematic review found in the literature examined educational needs for the primary care workforce (Howarth et al., 2006). The impetus for the study was based on the need to develop competent workforce teams with nurses as key members. This was done through appropriate educational means in order to help address changes in the delivery of primary healthcare that have occurred as a result of globalization. The study's findings were reflective of attributes and skills identified for the effective delivery of patient care and included the following themes: leadership, communication, teamwork, role awareness, personal and professional development, practice development, and partnerships (Howarth et al., 2006).

Three other literature reviews related to study abroad programs and cultural competences of future nurses were found in the literature. Edmonds (2012) specifically examined the historical development of study abroad programs for nursing students since the topic first surfaced in the literature in the 1990s. Review of anecdotal reports as well as research studies were examined. Implications of the review suggested study abroad programs provided effective learning opportunities but the evidence soundly supporting this was lacking. In addition, qualitative studies focusing on the lived experiences of study abroad students were called for as well as research with more diverse students (e.g., the major of study participants were Caucasian females between the ages of 18 and 23). The specific number and types of articles reviewed was not available in the literature review.

Kokko's (2011) review of the literature focused on the time frame from 2000 through 2009 in part because of McAuliffe and Cohen's (2005) literature review reported information from the early 1980s through 2004. In addition, Kokko (2011) limited the search to student exchanges involving use of a language other than English one's own during the study abroad experience. Qualitative content analysis was used to descriptively analyze the data and synthesize the findings. Three main themes were identified: (a) increased cultural knowledge base, (b) personal growth, and (c) impact of exchange experiences on the nursing student's own practice. The chief result of the review demonstrated the development of cultural competence during study abroad experiences. The author suggested future research on how acquired skills in an immersion experience are utilized in future nursing practice as well as how the experience influenced career planning and job market mobility.

The final systematic literature review was designed to critically investigate the existing empirical literature regarding immersion experiences in nursing education (Kulbok et al., 2012).

A total of 23 articles published between 2003 and 2010 were reviewed. The article includes a table that provides an overview of each research study appraised. Major study characteristics were listed including authorship and identified countries, the nature of immersion experiences, design of research, and study sample. Findings pertaining to culture and global health made note that the terms culture and global health were the chief goals of international programs. Primary study abroad program barriers were described and included stress, language skill, and cultural differences, for example. The authors concluded that nursing faculty should work with their international colleagues to build relationships and develop partnerships. Students from the sending and host country should have opportunities to participate in study abroad programs as well. Finally, mutual goal setting between partnership entities needs to be included in study abroad experiences.

In addition to the literature reviews noted above, a combination of nursing research studies utilizing quantitative, qualitative, and mixed methodology relevant to and/or supportive of outcomes from global healthcare immersion experiences were reviewed. A number of these studies focused specifically on development of cultural competence, a concept embedded in the literature on global healthcare immersion experiences (Amerson, 2010; Kardong-Edgren, 2007; Kardong-Edgren & Campinha-Bacote, 2008; Koskinen & Tossavainen, 2004; Sargent, Sedlak, & Martsof, 2005; Walsh & DeJoseph, 2003).

Enhancement of cultural competence. Four qualitative studies that focused specifically on the development of cultural competence were reviewed. In Walsh and DeJoseph's (2003) exploratory descriptive study centered on pre- and post-global healthcare immersion experiences. Interviews and focus groups were completed with students and faculty alike to discover themes pertinent to the development of cultural competence. Thematic findings included: (a) awareness

of being different, (b) fear related to skill level, and (c) an enlarged worldview. Research finding suggested that short-term global immersion experiences were important vehicles in enhancing awareness of global communities (Walsh & DeJoseph, 2003).

Koskinen and Tossavainen's (2004) interest in understanding the actual process of how students develop cultural competence led to an ethnographic study of Finnish nursing students participating in a three- to four-month global immersion experience. Three overarching themes were derived from the study and included a transition from one culture to another, a period of adjustment, and a time of increasing cultural sensitivity (Koskinen & Tossavainen, 2004). Although a global immersion experience was deemed an important method to learn about diversity, development of cultural competence was hindered by problematic orientation, stress in the study abroad phase, and re-entry challenges (Koskinen & Tossavainen, 2004). These findings lend credence to the importance of faculty role in preplanning, orientation, and reentry issues noted in Haloburdo and Thompson's (1998) dimensional matrix for immersion experiences.

In Larson, Ott, and Miles' (2010) descriptive study, the impact of a short-term immersion experience on cultural competence levels in nursing students was explored. Three themes emerged from analysis of the in-depth reflective journals. First, expression of coping skills and practicing health behaviors was identified as the navigating daily life theme; whereas, the second theme, broadening the lens, described aspects of daily life during the immersion. Making a difference, the last theme, including success in learning activities accomplished while immersed in the experience.

Carpenter and Garcia's (2012) descriptive study utilized survey results and qualitative methods to investigate the connection between students' immersion program experiences and

changes in cultural competence. A modified Cultural Awareness Survey was used in the pre- and post-immersion settings with a convenience sample of 35 participants in two cohorts. Five subscales were evaluated. The mean of the general learning experiences subscale related to students' perceptions of their classroom learning was well above the midpoint (e.g., 4.7 on a 7.0 scale). The awareness and attitudes subscale regarding the influence of cultural beliefs and attitudes on behavior had the highest mean at 5.7. The behaviors and comfort with interaction, clinical practice, and post-study abroad perspective subscales had means of 5.5, 6.1, and 6.3, respectively. The survey and subscales had good reliability. Qualitative findings supported survey results.

Kim et al., (2006) took a different approach to their study as their research aims were focused on identifying principal values in global leadership development as well as competencies needed for global nurse leaders. Key leadership tenets identified from the literature found that leaders are both born and made, bring sustainable results, and have the ability to inspire others. Whereas core competencies desired for global nurse leaders included cultural sensitivity, flexibility, resilience, integrity, and building relationships. Thematic findings, as noted above, were developed from a synthesis of business leadership literature and structured interviews with nurse leaders who had been immersed in a global experience for a minimum of at least four weeks, respectively. The lack of educational preparation for a global leadership role was emphatically stressed among study participants. Study findings support ongoing efforts to develop cultural competence in nurse leaders particularly through educational endeavors.

Two other studies looked at the use of faculty or tutors to enhance culturally congruent care. First, Koskinen and Tossavainen (2003) examined the tutor/nursing student relationship of British students working with Finnish instructors. The primary finding from this study relates to

cultural sensitivity and the tutor/student relationship that was more pastoral or caring than academic. The primary reason for this was because tutors spent time assisting students who were experiencing culture shock. The pastoral role of tutors was not viewed negatively, but thought to enhance cultural sensitivity. Second, Mixer (2011) examined nursing faculty care practices and how they support or provide culturally sensitive care of nursing students. The organizing framework of this study was Leininger's culture care theory. Themes identified in the data focused on the idea that faculty care is value-laden and embedded in religious beliefs and practices. Other themes related to faculty care expressions and patterns for teaching.

Several studies utilized Campinha-Bacote's (2007) process of cultural competence in the delivery of healthcare services as their theoretical framework that was developed in the late 1990s. An understanding of the concept of culture and its relationship to healthcare was implicit to this dynamic model that included the five main constructs: cultural awareness, cultural knowledge, cultural skill, cultural desire, and cultural encounters (Campinha-Bacote, 2007). In addition, the Inventory to Assess the Process of Cultural Competence Among Healthcare Professionals[®] (IAPCC[®]), or the revised version (e.g., IAPCC-R[®]), developed based on the constructs of the model, was used to measure levels of cultural competence in research discussed below.

Of the studies conducted utilizing Campinha-Bacote's (2007) process of cultural competence model, Sargent et al.'s, (2005) research was designed to assess assimilation of cultural content from a revised curriculum by comparing levels of cultural competence with a convenience sample of first and fourth year BSN students and faculty. Mean score differences of cultural competence levels from the original tool (IAPCC[®]), were examined in a one-way analysis of variance (ANOVA). Significant findings were reported between group scores with

higher levels of cultural competence in fourth year students and faculty as compared to first year students. In addition, there was a significant correlation between higher cultural competence scores and participants who had visited foreign countries as compared to participants who had not traveled internationally.

Kardong-Edgren (2007) designed a randomized, cross-sectional, descriptive survey study to evaluate cultural competence levels in 170 BSN faculty. Participants were stratified according to the numbers of immigrants (high or low) living in their respective states of residence. An independent samples *t-test* was used to compare levels of cultural competence measured by the revised instrument (IAPCC-R[®]), with significant cultural competence levels in faculty teaching in states with high numbers of immigrants. A key finding from the descriptive portion of the study was that faculty attributed their increased comfort in caring for immigrants was based on previous exposure that included face-to-face encounters with immigrants, although it was unclear whether these encounters came from personal experiences or professional practice opportunities.

The third study (Kardong-Edgren & Campinha-Bacote, 2008) in this grouping used a post-test descriptive design to measure cultural competency levels with the IAPCC-R[®] in graduating students from four programs with differing curricular methods for achieving cultural competence. The student group with the highest mean scores had previously taken a cultural anthropology course and had the highest percent of students who were involved in a global healthcare immersion experience.

Lastly, Amerson (2010) utilized the Transcultural Self- Efficacy Tool (TSET) developed by Jeffreys (2000) to measure cultural perceptions (e.g., self-efficacy) through cognitive (cultural knowledge), practical (use of interview skills with clients of differing cultural backgrounds), and

affective (cultural values, attitudes, and beliefs) domains (Amerson, 2010; Jeffreys & Smolaka, 1999). A paired samples *t-test* with a convenience sample of 60 students was used to measure cultural competency perceptions after a cross-cultural, service-learning experience. Significant increases from pre- to post-test were found in total score means as well as in each of the three subscale scores (e.g., cognitive, affective, and practical domains) suggesting that students participating in the global immersion experience had higher self-perceived cultural competence levels than students whose clinical practicum was not an international setting (Amerson, 2010). Results of this study also support findings specific to cognitive development from Zorn et al.'s (1995) research. (See below under Short- and Long-Term Outcomes.)

Model development. A grounded theory approach was utilized in Haloburdo and Thompson's (1998) study examining the meaning of a global immersion experience for BSN students as well as learning outcomes from the experience. A second component of the study compared learning outcomes among BSN students who traveled to developed versus developing countries along with the students who participated in direct patient care versus those who did not. Identified themes included growth in personal and professional domains (e.g., cultural sensitivity, communication, and personal knowledge), empirical knowledge (e.g., sociopolitical resources), and the actual learning experience (e.g., benefits gained and teaching/learning strategies). Interestingly, outcomes were negatively affected by learning experiences lacking a hands-on component, rather than the type of country visited. As a result of this research, a model for learning was developed that included: (a) a faculty role in preplanning, orientation, and reentry issues; (b) utilization of experiential learning opportunities; (c) integration of the immersion experience in the academic curriculum; and (d) a two week concentrated experience guided by a faculty or local liaison (Haloburdo & Thompson, 1998). Results of the study

suggested that BSN student learning outcomes may be achieved through participation in global immersion experiences.

Similar to Haloburdo and Thompson's (1998) study, the primary purpose of Ryan and Twibell's (2002) study was to validate the dimensions of a matrix for personal and professional growth through a global immersion experience. An additional goal of the study was to develop a model of global immersion experiences that would serve as a guide for nurse educators. The Transcultural Nursing Immersion Experience Questionnaire (TNIEQ) (Ryan, Twibell, Brigham, & Bennett, 2000) was developed based on the dimension of the model and was administered to a purposive convenience sample of senior-level BSN students who participated in a short-term (e.g., two to three weeks) immersion experience. Modifications in the matrix were made based on the findings from the study and resulted in the following: (a) situational predetermining factors including antecedent conditions such as educational preparations, knowledge of the host culture, personal characteristics and experiences, and professional experiences; (b) modifying factors incorporating the context of the experience such as the specific type of experience, people at the site, and the participant's personal response; (c) traditional factors including strategies to adapt such as coping mechanisms, communication, and social support; and (d) outcomes including personal and professional growth that leads to new insight and perspective as well as a changed practice (Ryan & Twibell, 2002).

Henry and Ueda's (2005) research was directed specifically towards the development of a learning model for international health in nursing. The impetus for this study came in response to the growing number of global health endeavors involving nurses, such as immersion experiences, and the lack of standards to appropriately guide inquiry and curriculum. The aim of the study was designed to construct a framework that could be used as a guide to the

implementation and evaluation of international nursing education curriculum. Content analysis of programmatic descriptions, higher education policy documents, and information from nursing associations was done. The resultant model included the five main concepts: environment, demography, culture, technology, and research. The concepts could potentially be utilized in planning curriculum that incorporated global health concepts. Goals and outcome competencies specific to each main concept were developed and included in the findings.

Read's (2011) study was not specifically designed for model development; however, incorporation of the study into this section of the literature review seemed logical. Read's (2011) interest in knowing more about the number of BSN programs in the USA that offered study abroad programs was the impetus for this study. Schools of nursing ($N = 780$) identified from the AACN website were mailed a pencil and paper survey. A 49% response rate was achieved with approximately 23% of the schools offering a full-semester study abroad experience. About 47% of these schools were categorized as private. Interestingly, schools reported that 0%-5% of students participate in study abroad programs. Perceived benefits identified by the respondents were consistent with findings previously described in the literature whereas perceived constraints of such programs centered on logistical and financial issues. Implications for future study primarily included long-term effects of short-term study abroad options.

Short-term outcomes. Participant outcomes from global healthcare immersion experiences were the focus of several research studies. Outcomes varied depending on the objectives and design of the study. For example, Zorn et al. (1995) examined cognitive development with a BSN student cohort in a quasi-experimental design utilizing Perry's theory of young adult cognitive development as the organizing framework. Students participating in the global immersion experience were expected to have higher cognitive changes as a result of the

exposure to diversity connected to it as compared to students who do not participate in an immersion experience. The Measurement of Epistemological Reflection (MER) tool was used to operationalize students' cognitive development. Although no significant differences were found between groups, student participation in the study abroad program positively influenced MER scores indicating enhanced cognitive development (e.g., intellectual development in decision making, evaluation, perceptual awareness, and role as learner and teacher), from a global immersion experience.

The purpose of Callister and Cox's (2006) phenomenological study was to gain insight into the lived experiences of undergraduate BSN students participating in a global immersion experience. Understanding the personal and professional meaning of the experience to participants was of primary importance to the researchers. A purposive sample of 20 BSN students was interviewed for the study. Seven themes were developed during the analysis of data from this study and included: (a) improved understanding of other cultures, (b) enhanced knowledge of global sociopolitical and health issues, (c) increased commitment to face global health challenges, (d) enhanced personal and professional growth, (e) increased contribution to the professional development of the host country, (f) improved interpersonal connections, and (g) increased levels of cultural competence. These findings were consistent with the results from Ryan and Twibell's (2002) evaluation of a dimensional matrix. Study results are being utilized in curricular changes for these types of experiences (Callister & Cox, 2006).

Torsvik and Hedlund's (2008) qualitative study explored the use of reflective dialogue (narrative pedagogy) as a means to develop nursing practice of students across countries. The intent of using this teaching pedagogy was to help bridge the gap in knowledge between Norwegian and Tanzanian students and across cultural contexts. Analysis of data from

participatory observation, student logs, and focus groups revealed that students from both countries experienced and reflected on several aspects of their nursing practices including their nursing role, perceptions of their responsibilities, and their relationships with patients and their families. In addition, findings were supportive of cultural encounters as an effective teaching tool with these participants with the potential for this type of learning to positively contribute to nursing practice within each culture. This last point corresponds to Callister and Cox's (2006) international learning framework component that a global immersion experience positively contributes to the professional development of the host country.

Morgan (2011) takes a different approach to short-term outcomes by examining students' perceptions of risk as it relates to immersion experiences. Many benefits of travel abroad programs have been identified in the literature, but research has not specifically addressed the risks linked to immersion experiences such as infectious disease exposure, personal harm, psychological issues, and accidents, for example. This phenomenological study utilized Banonis' philosophy of analysis on the data gathered from semi-structured interviews. Three themes were identified from the analysis including: types of risks (e.g., physical, clinical-professional, and socio-cultural); factors influencing perceptions of risk and risk management decisions (e.g., intuitive understanding, comparison with home, and friendly strangers); and risk and learning (e.g., risk and its positive effect on learning). Implications for future include using these findings to strengthen student support involved in immersion programs whereas limitations relate chiefly to whether or not the heuristics applied in this study were an appropriate choice.

Long-term outcomes. Lastly, a few studies have centered on long-term outcomes of global immersion experiences in students and practicing nurses. In this early study, Zorn (1996) evaluated the long-term impact on graduates from the same BSN program using an international

education survey developed for this non experimental descriptive survey study. The school of nursing evaluation model served as the organizing framework and centered on program components, evaluative questions derived from the school's mission statements, and summative evaluation questions. The four dimensions of the evaluation model that were tested included professional nurse role (e.g., impact on practice, relevance to nursing career, and efficiency and effectiveness in practice), global perspective, personal development (e.g., personal growth, decision making, and values and beliefs), and intellectual growth. Although the length and type of immersion experiences varied, results indicated that the personal impact of the exchange experience decreased over time (e.g., after three years) particularly for the participants whose program of study was shorter in length (e.g., 2 to 4 weeks). Longer-term effects such as an enhanced global perspective and personal growth were positively correlated with programs ranging from 12 to 16 weeks. This finding supports the contribution immersion experiences have on BSN students' global understanding.

Kollar and Ailinger (2002) completed a study similar to Zorn's (1996) in that they examined the long-term impact of a global immersion experience on BSN graduates as well. Descriptive information from a purposive sample was analyzed and compared to the International Experience Model (IEM). The IEM offers insight to what participants in an immersion experience can gain (e.g., knowledge, understanding, personal growth, and interpersonal relationships). Results of the study indicated participant outcomes related to an enhanced global perspective along with self-development (e.g., personal growth) as well as long-term personal and professional benefits from the immersion experience although it was unclear how much time had passed since students graduated.

In another study, Evanson and Zust (2006) were interested in describing the effects of an immersion experience on the personal and professional lives of nursing student participants' two years after the experience. Three themes were identified from the analysis and included coming to understand, unsettled feelings, and advocating for change. Implications of these results are that short-term global immersion experiences can have a longer-lasting effect on the lives of nurses and nursing student.

Participatory action research was used as the design in Reimer Kirkham, van Hofwegen, and Panratz's (2009) study that centered on how students' learning from a global immersion experience was translated to their environment at home. Research aims were to examine the nature of student learning regarding social justice in the context of an immersion experience and to identify approaches that would support students in incorporating this learning into their personal and professional lives. Each cohort group participated in repeat focus groups for up to a year after the experience. Findings resulted in significant learning for students, but challenges existed for sustainability of long-term efforts with incorporating social justice within the home environment. In addition, a preliminary framework for learning with similarities to other models reviewed in the literature (Callister & Cox, 2006; Haloburdo & Thompson, 1998; Ryan & Twibell, 2002) was developed for global immersion experiences. The four main guiding principles of the model include maximization of learning, equitable partnerships, structured organization of the immersion experience, and generation of knowledge (Reimer Kirkham et al., 2009). The element of structured organization (e.g., preplanning) for immersion experiences was also found in Haloburdo and Thompson (1998) and Koskinen and Tossavainen's (2004) studies.

A non experimental survey design was used in Smith and Curry's (2011) descriptive study of 36 students. Zorn's (1996) 29-item tool, the International Education Survey (IES),

designed to measure the impact of an immersion experience, was utilized in the study. Student demographics were collected on post-licensure education as well as clinical practice. Qualitative information was gathered from open-ended questions included with the survey. Means from the 7-point Likert-style survey were a minimum of 4.00 out of 7.00 on all items. Results were compared to Zorn's (1996) original study of 27 students with a noticeably stronger impact on professional role in the current study. Overall, the author's reported a gain in all four dimensions of the scale. Examples of limitations included sample size, length of immersion experience and differences in host location as well as transcultural educational course content (Smith & Curry, 2011).

Summary of the Review

Although the full impact of globalization on healthcare may never be known, complex healthcare challenges related to the effects of increased globalization such as rising numbers of culturally diverse patients already exists in the USA (Commission on Social Determinants of Health, 2007; 2008; Giger et al., 2007; Labonte & Schrecker, 2005; WHO, 2012). National mandates for improving quality of care in the USA demands innovative thinking related to the delivery of healthcare services (Giger et al., 2007; Huston, 2008; IOM, 2001; 2011; QSEN Institute, 2013b). Of particular interest are the endeavors of the Institute of Medicine (2011) and the Quality Safety and Education for Nurses project (QSEN Institute, 2013a; 2013b). The similarity of their respective goals and missions for healthcare to be client-centered, effective, timely, safe, and evidenced-based is supported in the literature and correspond with the missions of other educational organizations including nursing education accrediting bodies (AACN, 2008; Commission on Collegiate Nursing Education, 2009; NLN, 2003; 2005; NLNAC, 2010; 2012).

In response to this, nurses are actively involved in addressing healthcare issues arising from these challenges as noted by the review of anecdotal/descriptive and research-based literature. However, the work that is needed to address the growing global healthcare concerns and the ways in which healthcare workers, specifically nurses are being prepared to provide patient-centered and culturally sensitive care to diverse populations must be evidence-based (AACN, 2008; Benner et al., 2010; Giger et al., 2007; IOM, 2001; 2011; NLN, 2003; 2005; Plsek, 1997; QSEN Institute, 2013b). Furthermore, preparation of nurses at all levels and specifically in baccalaureate programs must focus on teaching/learning strategies that are experiential in nature and situated in clinical practice (Benner et al., 2010; Cope et al., 2000; Fink, 2003; Fink & Fink, 2009; Kolb & Kolb, 2005; Lave & Wenger, 1991). Moreover, the development and redesign of nursing curricula needs to include sound pedagogical practices that will provide transformational learning experiences in the classroom as well as in the variety of clinical settings where nurses practice, including global healthcare settings (AACN, 2008; Benner et al., 2010; Ironside, 2005; IOM, 2011; Kulbok et al., 2012; QSEN Institute, 2013b).

This review of literature stresses the importance for nurses to be educated to be able to practice and lead in the global health arena (Howarth et al., 2006; Kim et al., 2006; Swenson et al., 2005). It is clear that adequate preparation in areas of cultural awareness and the provision of culturally-congruent care will help provide better patient outcomes as well as meet nursing education standards such as accreditation guidelines (AACN, 2008; Giger et al., 2007; IOM, 2011; NLN, 2003; 2005; NLNAC, 2012). This review also demonstrates that nurses are developing educational programs such as global immersion experiences, international partnerships or exchanges, globally focused curriculum, international learning models, and international nursing accreditation guidelines to meet this global need. Educational practices and

programs also need to keep in mind that faculty behaviors, instructional design, and experiential learning are important for engaging students in the learning process (Fink, 2003; Gatzke & Ransom, 2001; Kolb & Kolb, 2005; Popkess & McDaniel, 2011; Pugsley & Clayton, 2003; Salamonson et al., 2009).

Furthermore, the growing body of literature pertinent to global healthcare immersion experiences demonstrates nurse educators' interest in learning more about the benefits of immersion experiences on the personal lives and professional practice of nurses and nursing students (Button et al., 2005; Callister & Cox, 2006; Edmonds, 2012; Kokko, 2011; Kulbok et al., 2012; McAuliffe & Cohen, 2005). The appropriate timing for examination of outcomes of a global immersion experience has been questioned with suggestions for waiting until nurses have gained knowledge and skill in their respective practice areas (Kardong-Edgren & Campinha-Bacote, 2008; Zorn, 1996) even though anecdotal accounts and research based studies attests to positive outcomes for nursing students (Andreatta & Hu, 2010; Bosworth et al., 2006; Callister & Cox, 2006; Kokko, 2011; Kuehn et al., 2005; Kulbok et al., 2012; Torsvik & Hedlund, 2008; Zorn et al., 1995).

The literature reviewed demonstrates that research is being conducted related to global healthcare immersion concepts. Nonetheless, it is clear from the limited number of available descriptive- and research-based studies specifically related to students' perceptions about the educational process, as well as the lack of studies building on findings of previous work in the area of global healthcare immersion experiences, that more research is necessary. Many of the studies call for future research in the areas of short- and long-term benefits of a global health immersion experience for nursing students understanding that cultural proficiency is needed for all nurses, particularly those taking on global leadership responsibilities. Moreover, models are

being developed with the potential to guide educator efforts in developing and/or revising curriculum with increasing focus on utilization of global immersion experiences for nursing students. Finally, strategies to support nursing students in the preplanning stage of a global immersion experience, activities of the immersion, and adjustment to reentry stage of the experience have begun to emerge in the research literature although primary research aims focused specifically on student perceptions is lacking (Haloburdo & Thompson, 1998; Koskinen & Tossavainen, 2004; Reimer Kirkham et al., 2009).

Summary of Significance to Nursing

It is clear that greater attention is being given to health on the global agenda as well as in professional nursing education and practice arenas (Commission on Social Determinants of Health, 2007; 2008; Huston, 2008; Kaul & Faust, 2001; WHO, 2012). Moreover, it is vital that every domain of healthcare related to education and practice is strengthened (Drager & Beaglehole, 2001; Huston, 2008; IOM, 2011; WHO, 2012). Along with this, nurses, who are in the vanguard of providing patient care by virtue of their numbers and the diversity of settings where they practice (e.g., hospitals, clinics, educational systems, businesses, and homes), must be educated to be knowledgeable in understanding how to maximize the positive outcomes of globalization on health and skillful in reducing the harmful effects (Drager & Beaglehole, 2001; IOM, 2011; Jairath, 2007; WHO, 2012). This review clearly shows the gap in the literature calling for research studies to address these critical areas. Furthermore, studies have been conducted with faculty and postgraduate student teachers (Barkhuizen & Feryok, 2006); however, with the exception of Koskinen and Tossavainen's (2004) ethnographic study describing an immersion program as a means of learning cultural competence, primary research

aims have not focused specifically on student perceptions of the preparation, interface, and post-immersion experience.

Chapter Three

Methodology

This study was designed to describe components considered most essential in designing a short-term global healthcare immersion experience for BSN students that will enhance professional development in nursing practice in the areas of cultural understanding and global awareness by exploring the following research questions:

1. What is the student perception of his/her ability to perform in a global health setting in the preparation, cultural interface, and post-immersion stages? (Self-efficacy)
2. What is the student perception of the educational information including clinical training that is needed in the preparation, cultural interface, and post-immersion stages of the global health experience? (Cognitive/Practical)
3. What is the student perception of the benefits and the gaps of the mentoring that support their cultural understanding in the preparation, cultural interface, and post-immersion stages of the global health experience? (Practical/Affective)
4. What is the student perception of how they will integrate this global immersion experience into their personal and professional lives? (Affective)

The study design, methods (sample, setting, data collection procedures, data analysis procedures), limitations, and ethical considerations will be presented in this chapter.

Study Design

A qualitative descriptive design was necessary for the study since quantitative methods do not support a comprehensive approach of multifaceted situations (Marshall & Rossman, 2006; Sandelowski, 2000). Qualitative description allowed the researcher to explore the perception of BSN students while limiting the need for interpretation or theorizing and therefore focusing on

the need to accurately understand the reality presented through the data collection. Qualitative descriptive studies have been conducted with faculty. However, with the exception of Koskinen and Tossavainen's (2004) ethnographic study describing an immersion program as a means of learning cultural competence, primary research aims have not focused specifically on student perceptions of the preparation, interface, and post-immersion experience.

This narrow focus supported the need for the rich description that comes from a qualitative approach (Marshall & Rossman, 2006). Furthermore, BSN students were provided the opportunity to give their perspective and perceptions of aspects deemed most important in designing a short-term (e.g., 1- to 4-weeks in duration) global healthcare immersion experience (GHIE). Global immersion experiences have the potential to enhance professional development in nursing practice pertinent to cultural competence and awareness of global health concerns. Since it is important in qualitative research to gather as much data as possible in order to capture every component of an event (Sandelowski, 2000), artifacts and observations (e.g., course documents, participant reflective journals, faculty/participant debriefing sessions, and field notes) were used in this study to understand the participant perspective (Baillie, 1995; Hodgson, 2001; Patton, 2002; Wolf, 2007). Key concepts (e.g., self efficacy, cognitive, practical, and affective) from the cultural competence and confidence (CCC) model (Douglas & Pacquiao, 2010a; 2010b; Jeffreys, 2000; 2010; OJCCNH.org, 2013) were selected as the organizing framework for the research. This model was chosen because of its multidimensional teaching-learning process that integrates concepts based on psychology, transcultural nursing literature, and education's cognitive, practical, and affective learning domains.

Sample

The sample for this study was purposively selected from senior-level BSN students ($N = 14$) enrolled in the *Nursing (N) 490 Professional Practicum: Study Abroad Option* elective course offered at a Midwestern University School of Nursing (SoN) in the Spring 2012 semester. The *N490 Professional Practicum* course is the capstone course for all senior BSN students in the program. The primary objectives of the course are more general in nature (rather than directly related to a study abroad experience) and focused on helping students function in a professional practice role that integrates leadership principles designed to enhance critical thinking abilities. Capstone placements typically vary depending on student interest as well as availability of capstone preceptors and clinical sites. The required student reflective journals for this practicum were designed to provide an overview of weekly clinical activities and followed a standard format. In addition, they were utilized mainly as a communication tool with the practicum preceptor for the capstone experience (V. Hicks, personal communication, January 12, 2012). In this course 4-week study abroad option, students learned about international nursing through discussion and application of concepts and theories of global healthcare. Furthermore, students learned leadership roles and responsibilities of providing healthcare to clients in a developing country through a short-term (e.g., 4 week) immersion experience (V. Hicks, personal communication, September 12, 2011). Students were expected to attend pre- and post-immersion experience class activities such as team meetings as well (V. Hicks, personal communication, January 27, 2011).

The number of students allowed to participate in the study abroad option (immersion experience) was limited. Although a total of 14 students who enrolled in the Spring 2012 course study abroad option participated in the immersion experience (V. Hicks, personal

communication, January 12, 2012), only nine of the course enrollees agreed to participate in this study.

Support and rationale for sample size. In general, criteria for sample size in qualitative research are non-specific (Patton, 2002; Polit & Beck, 2004). Polit and Beck (2004) suggests that an appropriate sample size is one that can best provide information to address the study aim whereas Patton (2002) recommends considering sampling for cases which are information rich that will yield an in-depth perspective and insight regarding the phenomena of interest in a study such as this one. The limited numbers of students able to participate in a global healthcare immersion experience is not unusual and is related to a variety of reasons including, but not restricted to student interest, length of the immersion experience, personal and/or professional responsibilities, available support (e.g., financial), accessible housing at the host location, the number and nature of other projects in process at the host location, and state board of nursing guidelines for faculty/student ratio in clinical settings (e.g., 1:10) (Kansas Board of Nursing Nurse Practice Act, 2012).

Determination of and support for sample size came from qualitative research literature on short-term (e.g., 1-4 weeks duration) global healthcare immersion trips, whose participants were nursing students. Sample size was reported in the following studies meeting the above criteria: Haloburdo and Thompson (1998) $N = 14$; Koskinen and Tossavainen (2004) $N = 12$; Larson et al. (2010) $N = 13$; Reimer Kirkham et al. (2009) $N = 17$ (Cohort 1, $n = 8$; Cohort 2, $n = 9$); Torsvik and Hedlund (2008) $N = 14$ (Norwegian students, $n = 4$; Tanzanian students, $n = 10$); and Walsh and DeJoseph (2003) $N = 10$. Based on average numbers of participants from previous research, the recommended sample size in this type of study would range from 10 -14 participants for data saturation to be achieved. However, because of the known limitation in the

course study abroad option enrollment numbers (e.g., maximum of 14 students) the recommended sample size will reflect this number. Moreover, the integration of artifacts and observations (e.g., course documents, participant reflective journals, faculty/participant debriefing sessions, and field notes) were utilized to help support the need for information rich cases (Patton, 2002) in the study. Depth, versus breadth, was desired to answer the research questions.

Inclusion/Exclusion Criteria

Course enrollment assumed students were in good standing from the University's and SoN perspective and included up-to-date tuition payments and non-probationary academic standing. Students were expected to complete the course requirements for both the didactic portion and the clinical portion of the course. Students participating in the study abroad option were expected to complete the 4-week global healthcare immersion experience (while abroad) as well as the rest of their professional practicum experience (e.g., capstone experience) once they returned to the USA. The study abroad clinical portion of the course and the 4-week global healthcare immersion experience are synonymous. In addition, students were asked to participate, if possible, in all phases of the research including two focus group interviews of 60-90 minutes (one focus group in the pre-immersion phase and one in the post-immersion phase), informal interviews during the pre- and post-immersion experience activities (e.g., planned course meetings and team/individual presentations) as well as for member checking methods done for summary and clarification of information at the end of each focus group.

Although students were not required to have background knowledge of the host country's primary language to participate in the global immersion experience, they were required to have fluency in English to participate in the study. The sample *Letter of Invitation* (Appendix A), the

Research Consent forms (Appendices B and C) as well as the *Demographic Questionnaire* (Appendix D) were written in English. Furthermore, all formal and informal interviews and focus groups were conducted in English. Students were required to meet the cost of travel expenses (e.g., airline ticket, passport, insurance, room and board, and incidentals) which was above the normal cost of course tuition. Students were excluded if they did not meet these inclusion requirements. All students who expressed interest in joining the study met the inclusion criteria therefore; no one was excluded from the study.

Setting

Academic setting. The School of Nursing (SoN), at a large, University in the Midwest, was the setting for data collection. The SoN was an appropriate setting because it was the physical location where students attended classes for their nursing curriculum. Although student participants traveled abroad to the host organizations, data collection (e.g., all focus groups, participant observations in the pre- and post-immersion phases, poster presentations, and informal interviews with course faculty and student participants) occurred only at the SoN. Two faculty instructors were designated for the study abroad option because the enrollment numbers ($N = 14$) exceeded the state board of nursing guidelines for faculty/student ratio in clinical settings (e.g., 1:10) (Kansas Board of Nursing Nurse Practice Act, 2012). Therefore, in order to have access to the setting at the SoN and course enrollees, the primary faculty instructor for the course study abroad option acted as the gatekeeper (e.g., a person who has influence over others in the field and/or are in position of control or authority [Hodgson, 2001]) for the study. In addition, access to and appropriateness of utilizing host organizations in the international settings (e.g., Amsterdam, Ecuador, India, Ireland, New Zealand, and South Africa) had been established

previously through contractual arrangements and was evidenced by the ongoing relationship with the University and the SoN (V. Hicks, personal communication, January 12, 2012).

Location of the global healthcare immersion experience. The global healthcare immersion experience took place in a variety of international settings (developed and developing countries) including the following: University Medical Center, Amsterdam (one student); Medical Facility, Quito, Ecuador (one student); Christian Medical College, Vellore, India (four students); Wexford City Hospital, Wexford, Ireland (one student); and University of Witwatersrand, Johannesburg, South Africa (two students). Auckland City Hospital, Auckland, New Zealand was also a study abroad location however, students assigned to this facility chose not to participate in the study. These were appropriate settings for the immersion portion of the course study abroad option. Contracts with host organizations were previously established and were up-to-date therefore; access to these settings was facilitated through the SoN.

Human Subject Considerations

Institutional Review Board Approval

Institutional Review Board (IRB) approval from a Midwestern university was obtained prior to recruitment of participants. Although the researcher was not interested in studying the client population in the host countries, students participating in the immersion experience, interfaced with clients, their families, the local community, as well as collaborated with other members of the healthcare team in the host country and with the host organization. In addition, data collection (e.g., participant observations and informal interviews during required meetings and other activities) occurred with SoN undergraduate BSN students during their pre- and post-global healthcare immersion experiences.

Procedures

Prior to IRB approval, the researcher had opportunity to participate in a study abroad class session with course faculty and students enrolled in this course option. Since the study was not yet approved, the express purpose of attending the meeting was for students to become familiar with the researcher, of importance to qualitative research (Patton, 2002). No recruitment was done until after IRB approval. Following IRB approval, the researcher contacted the primary course instructor and gatekeeper and asked her to share the *Letter of Invitation* (Appendix A) with the students enrolled in the *Nursing (N) 490 Professional Practicum: Study Abroad Option* portion of the course. Specific information identifying the date, time, and location of the pre-immersion focus groups was announced at the bottom of the *Letter of Invitation* (Appendix A) in a separate color of ink. In order to prevent confusion with other students enrolled in their professional practicum, the *Letter of Invitation* (Appendix A) was then communicated by the gatekeeper only to potential participants (e.g., students enrolled in the study abroad practicum) via the University's email system (instead of through *Angel*, the course's learning management system) approximately 36 hours prior to the first scheduled focus groups. Ideally, the *Letter of Invitation* (Appendix A) was to be sent one week and then again at 72 hours prior to the pre-immersion focus groups. However, this did not occur primarily related to scheduling issues with the researcher as well as the students' school schedules and their impending departure dates for the immersion experience. Presentation of the invitation letter by the primary course instructor served as a means of introduction for the researcher as well as for the research study. Receipt of the letter within the short time frame of 36 hours prior to the pre-immersion focus groups scheduled on January 20, 2012, did not allow potential participants much time to think about the study, ask questions, and contact the researcher of their interest in

participating in the study. Nonetheless, several students made email contact with the researcher within this time frame expressing their interest in joining the study, while others simply showed up for one of the two scheduled focus groups.

Of the 14 enrollees to the study abroad option, eight students meeting the inclusion criteria joined the study during the pre-immersion focus groups. Because the recommended sample size was a minimum of 10, it was determined through consultation with the researcher's research advisors to seek IRB approval allowing students to be included in the study if they were able to participate in at least one of the focus groups (either in the pre-immersion phase and/or in the post-immersion phase). An additional *Research Consent* form was developed and subsequently approved by the IRB (See Appendices B and C).

Furthermore, communication of these changes was made to the study abroad course enrollees during each of the two faculty instructors' debriefing sessions (both in the month of March) with their respective students shortly after they returned to the USA or within about one week of their return. Specifically, the researcher was given a few minutes in each of these sessions to announce the aforementioned changes and answer questions pertaining to the study, as appropriate. In addition, the *Letter of Invitation* (Appendix A) as well as an announcement of the details (e.g., date, time, and location) of the post-immersion focus groups was sent as an attachment via the University's email system to current research participants as well as other study abroad option students not enrolled in the study. This was done approximately one week prior to the scheduled focus groups on April 23, 2012. Because this was also a busy time of the semester for the students, a reminder email was sent 72-hours ahead of the post-immersion focus groups as well. Although, a couple of students responded to the communication, the rest of the students simply showed up for the focus group. By taking these steps, another participant who

met the inclusion criteria was added to the study in the post-immersion phase, thereby increasing the number of study participants to the total (e.g., $N = 9$).

Research Consent Forms

As students agreed to participate in the study, a copy of the *Research Consent* form (Appendix B or C) was given to them to read and sign followed by administration of the *Demographic Questionnaire* (Appendix D). The consent was reviewed with questions about the study clarified, prior to obtaining participant signatures. More time was allowed for questions about the study in the pre-immersion focus group because of the short-time frame (e.g., 36 hours) of prior notification. A copy of the consent form was given to all participants for their records. Furthermore, the researcher was available in person at a variety of other team meetings (e.g., course informational meeting, debriefing sessions, and the poster-presentations) and via e-mail and/or phone contact to answer questions as needed pertaining to the study. Students meeting the inclusion criteria noted above were asked to participate, if possible, in two of four audio-taped focus group interviews offered (one during the pre-immersion phase and one during the post-immersion phase) that lasted 60-90 minutes, informal interviews during required meetings and activities, and for permission to read their reflective journals that were required for the course. In order to compensate students' willingness to participate in the study and in an effort to minimize attrition rates, food (e.g., drinks such as juice and water as well as snacks including fresh and dried fruit, nuts, chips, energy bars, and candy) were provided and available during each of the scheduled focus group or for a total of four times during the study. In view of the fact that students were going on a global immersion experience, with some going to developing countries, it seemed more appropriate to offer food to minimize attrition rates rather than items such as gift cards.

Anonymity in this study was not guaranteed for the following reason: The researcher was responsible for collecting the data. Nonetheless, confidentiality of study participants' information was assured and maintained. Moreover, the researcher did not assist in any way in evaluating students for their course grade. Use of pseudonyms was employed to protect the personal identity of each participant. Transcriptions of focus group interviews were maintained in a secured file as required by the review board for the University.

Data Collection

Phases of Data Collection

Essentially, data collection for this study took place over the course of an academic semester (e.g., approximately four months) and was divided into three phases (e.g., pre-immersion, immersion or cultural interface, and post-immersion). A variety of data collection methods were utilized across all three phases to support various ways of knowing by the researcher (Patton, 2002) and included demographic information; document and artifacts review such as the course syllabus, course required reflective student journals (with student permission), mandatory trip documents; focus groups; informal interviews with student participants and assigned course faculty; attendance at team/individual poster presentations; participant observation; and field notes. Furthermore, the importance of including observations in the data collection procedures has been established (Munhall, 2007; Patton, 2002). Therefore, observations made during interviews (e.g., body language, display of emotions, changes in the cadence and inflection of voices, and use of silence) were collected.

Several data collection methods (e.g., participant observation, field notes, and informal interviews) that were utilized specifically in the pre- and post-immersion phase are further described. Participant observation involves direct observation of human relationships and socio-

cultural events of the everyday life of people in their natural settings (Baillie, 1995; Powers & Knapp, 2006; Wolf, 2007). The range in which an observer participates can be viewed as a continuum or from complete participant to full observer and depends on the nature and context of the study. Essentially, participant observations must provide meaningful data therefore; the amount of participation by the researcher will vary depending on the particular event, situation, or circumstance (Baillie, 1995; Patton, 2002; Powers & Knapp, 2006). Field notes are detailed descriptions of the activities, observations, settings, dates, times, places, as well as informal interviews that occur during the pre- and post-immersion experience (Patton, 2002; Powers & Knapp, 2006; Wolf, 2007). In addition, field notes were recorded by the researcher and help provide the thick, rich description necessary for this type of study (Wolf, 2007). Informal interviews are characteristically a type of interview that can vary from spontaneous, casual (informal), or more structured, depending upon the information desired by the researcher (Baillie, 1995; Wolf, 2007). For the purpose of this study, the researcher was a participant observer of student participants during activities such as team meetings (e.g., orientation, team/individual presentations, and debriefing sessions). Informal interviews occurred primarily with student participants or other informants such as course faculty. Finally, detailed record of observations and informal interviews were documented in the primary researcher's field notes and utilized in the analysis of the data as well. Data collection methods in each phase of the research are summarized in *Table 2*.

Communication via email and personal contact with study participants occurred prior to each data collection point and served as a reminder for continued participation in the study. Reminder notices for each upcoming data collection point was sent out in advance of the event. It was important to schedule and plan data collection points particularly after the global

healthcare immersion experience to help prevent attrition related to semester end activities such as final exams, capstone experiences, or graduation, to name a few. A schedule of semester end activities was sought from the course faculty to assist the researcher in planning such activities.

Since data collection occurred during some of the winter months, and students lived off campus in the surrounding communities, a back-up plan for focus group interviews was in place in case of inclement weather. Even though the weather during the pre-immersion focus groups was wintry (e.g., cold and snowy), it was unnecessary to employ the contingency plan. In addition, inclement weather contingencies existed, but were not needed with the post-immersion focus groups scheduled in April.

Table 2

Summary of Data Collection Methods

Phase	Data Collection Methods
Phase I: Pre-Immersion	Recruit participants Sign consent form Demographic questionnaire Focus group interview (60-90 minutes) Participant observations Researcher as instrument Trip preparation Course syllabus Class activities Trip documents
Phase II: Immersion or Cultural Interface	Immersion experience (Researcher as instrument) Field notes Informal interviews with course faculty Course required student reflective journals (with student permission)
Phase III: Post-Immersion	Recruit additional participants Sign consent form Demographic questionnaire Class activities Participant observations Poster presentation by students Focus group interview Data analysis Field notes Researcher as instrument Member-checking

Phase 1: Pre-immersion. Phase I began following IRB approval in January after the start of the Spring semester. Recruitment of participants took place in this phase and included all activities that were accomplished prior to the short-term global healthcare immersion experience. For example, students actively participated in the pre-trip preparation including completion of required paperwork for the trip as well as course requirements such as regularly scheduled discussion forums, required reading, and attendance at team meetings, as described in the course syllabus.

Demographic data was collected in this phase. The *Demographic Questionnaire* (Appendix D) included questions about gender, marital status, ethnicity, age, state and/or country of permanent residence, place of birth, number of trips taken outside of the USA, the reason for the trip, and the length of time (in days or weeks) spent outside of the USA, and sources of funding.

In addition, two 60- to 90-minute focus groups were scheduled at the University SoN around class time during this phase within one week prior to the departure dates for the immersion experience. Although two focus groups for approximately four to five participants were planned to provide an opportunity to capture student perceptions related to the preparation for the global healthcare immersion experience, the numbers of participants in the pre-immersion focus groups were uneven (e.g., Focus group one had two participants whereas focus group two had six participants). A probable cause for this was related to the time each of the focus groups was scheduled (e.g., the second focus group was scheduled immediately prior to a required class). In addition, two focus groups at pre-immersion and two at post-immersion allowed students to choose one that best fit their schedule during this part of the semester. Although two

focus groups were scheduled in the post-immersion phase, it is important to note that all students attended the same focus group scheduled earlier in the day.

Focus groups were audio-taped and transcribed verbatim by a professional transcriptionist. A research assistant, whose primary role was that of a scribe, took notes during the focus group as well. Clarification of participant responses was done throughout each focus group and served as a means of member checking. Participants were provided the opportunity to include additional information as desired, at the end of each focus group. Benefits to utilizing focus groups included the following: they were a cost effective means of collecting data, data quality was generally enhanced because of the interactions that occurred; and they tended to be more enjoyable for participants than single interviews (Patton, 2002). Limitations of focus groups include greater restrictions on the number of questions that were asked in this type of setting, available time for responses was considerably less, and strong group facilitation skills were needed (Patton, 2002). A research assistant skilled and experienced in qualitative research methods, including group facilitation skills was essential to include in this study. Specifically, two research assistants participated in each of the pre-immersion focus groups, one as the scribe, and one who provided assistance as a group facilitator, while another research assistant was available to help with the post-immersion focus groups, primarily as a scribe. Finally, focus group interviews were conducted on a day when students were already scheduled for class; at the SoN in a designated classroom, a place familiar to students, and at a time convenient for them. Brightly colored signs directing students to the focus group were placed strategically within the SoN (e.g., by the bank of elevators, the stairwell, and points of entry to the lobby). Researcher training in conducting focus groups is addressed in the section pertaining to this.

In qualitative research, it is important for the researcher to establish a relationship of trust with the course faculty and enrollees (Baillie, 1995; Hodgson, 2001; Polit & Beck, 2004). Utilization of the primary course instructor as a gatekeeper to gain access to the other course faculty, student participants, the course, course documents, and the research settings at the beginning of the semester provided a means for establishing these relationships. Planned participation in the scheduled classes for the course study abroad option was also important for student participants to begin to see the researcher as a natural component of the pre- and post-immersion sessions for this global experience. The researcher was aware that she easily could have been seen as an outsider or another instructor, and not completely accepted into the group being studied. See also *Table 2* for a summary of data collection methods executed in this phase.

Phase II: Immersion. Phase II was the length of the short-term GHIE that was scheduled from late January through mid-March 2012, depending on where the students were assigned. For example, the students who traveled to India left the USA shortly after the pre-immersion focus group and returned the end of February, whereas the students who were sent to South Africa left a week to ten days later than the students traveling to India and came back closer to mid-March prior to the University's spring break. Although the researcher did not travel with the students to their respective international locations, data collection methods employed during this phase included the following: required student reflective journals, informal interviews with course faculty, and use of field notes (Baillie, 1995; Hodgson, 2001; Polit & Beck, 2004; Wolf, 2007) (See *Table 2*).

Phase III: Post-immersion. Phase III began when students returned to the USA from their immersion experience. Recruitment for additional participants was done in this phase as well because of the aforementioned changes to the *Research Consent* form (Appendix C).

Moreover, demographic data also was gathered from the newly recruited participant in the post-immersion phase. Although two additional focus groups similar in size were offered during this phase of data collection, the seven students who participated in the post-immersion focus group all came together. No students came to the second of the two post-immersion focus groups scheduled. Originally, the focus groups were to be scheduled within a month after the last students' immersion experiences ended. The actual date of the focus groups in this phase was a few days past a month of when the last students returned to the USA. Scheduling the focus groups was more challenging in this phase related to semester end activities and that students' availability was limited (e.g., students were on campus only one day a week). Students had the opportunity to again share their perceptions and perspectives related to preparation for the immersion experience, the actual experience, and how to best integrate what was learned into their personal lives and professional practice. The focus groups conducted in this phase was also audio-taped and transcribed verbatim by a professional transcriptionist. A research assistant, whose primary role was that of a scribe, took notes during the focus group. Clarification of information was done throughout the focus group with opportunity for students to include additional information as desired, at the end of focus group as a means of member checking. In addition, document and artifact review such as the course syllabus, poster presentations, required reflective student journals, and field notes was done during this phase of data collection. (See *Table 2*).

Focus Group Interview Questions

Original questions and associated probes posed in the semi-structured interview list were specific to the purpose of the study and were starting points for learning about the phenomena of interest within this culture of BSN student participation in global healthcare immersion

experiences. The interview questions were considered as general guidelines for interviews as an attempt was made to learn about what was most helpful in preparing students for the experience, the relationship of the study abroad and cultural interface, and the impact of the experience on the personal and professional lives of the students (Baillie, 1995; Hodgson, 2001).

Open-ended questions, which allow for open dialogue and a greater understanding of the world as seen by participants (Patton, 2002) were used to initiate the interviews. Open-ended questions also allowed students to describe their experiences in their own words whereas probes, used to deepen the response from the main questions, were used to clarify stated information (Patton, 2002). Introductory questions and probes can be found in the *Interview Guide* (Appendix E) that was utilized in the focus group interviews. Participants' conversation guided the probes used by the researcher. Focus group interviews were conducted in English and audio-taped by the researcher. The focus group interviews were then transcribed verbatim by a professional transcriptionist who completed all university Institutional Review Board confidentiality training requirements.

Researcher Training

Researcher training for qualitative methods included doctoral preparation (e.g., coursework) in qualitative research methods and application with instruction and mentoring from two experienced qualitative faculty researchers at the University. The researcher successfully completed training prior to the collection of data as required by the review boards such as the Conduct of Scientific Research study modules available at the University.

In addition, research assistants competent and experienced in qualitative research were recruited to assist in facilitating focus group interviews. Transcription of data from the focus groups during the study was completed by a professional transcriptionist as well. It was also

important for researcher to be adequately trained in leading a focus group. Although the researcher had not specifically led a focus group, she had most recently led and facilitated numerous class discussions with undergraduate students from her seven years of experience as a faculty member at a private liberal arts University with classes ranging in size from 11 to 74. Furthermore, she had experience facilitating group meetings with diverse populations through her work in administration at a non-governmental organization abroad and in consulting. In order to enhance her abilities to lead and facilitate the planned focus groups for the study, she read numerous articles specific to the task. Experience was also gained with each focus group conducted.

Researcher as Instrument

Because the researcher is the instrument in a qualitative study, the researcher set aside personal experience, biases, and expectations prior to the beginning of data collection (Patton, 2002). Objectivity was maintained throughout the study through continued reflexive journaling. Information related to the researcher as instrument pertinent to the study (e.g., experience, training, perspective, and prior knowledge of the research topic) (Patton, 2002) is included in the researcher's reflective journaling (Appendix F).

Qualitative Analysis

Demographic Data

Demographic data gathered from participants in the pre- and post-immersion focus groups was used to help describe the study sample. Demographic data provided a description of the BSN students participating in the study and was quantified as appropriate.

Description of study participants. A total of nine students participated in the study. Two of the eight participants who joined in the pre-immersion phase chose not to participate in

the post-immersion focus group without providing a reason. An additional participant joined the study in the post-immersion phase. More females ($n = 7$) as compared to males ($n = 2$) participated in the study. Participants' average age was 23.3 (range = 21-26) (see *Table 3*). All participants identified themselves as Caucasian with the exception of one. Similarly, all but one of the participants was employed with a reported number of hours worked per week averaging 15.78 – 17 hours. All but two participants reported travel abroad for vacation or holiday. The total number of trips reported by the seven participants who had traveled abroad was 28 with the amount of time out of the country ranging from five days to three months. The average length of the trips was one to two weeks. All of the participants reported contributing personal funds for trip expenses whereas six students reported receiving some type of University financial aid, primarily scholarship monies, for the immersion experience.

Table 3

Participant Demographics N = 9

Category	Frequency	Percent
Gender		
Male	2	22.2%
Female	7	77.8%
Current Age		
21-22 years	4	44.5%
23-24 years	2	22.2%
25-26 years	3	33.3%
Race		
Caucasian	8	88.9%
Asian	1	11.1%
Ethnicity		
Hispanic		
Non-Hispanic	9	100.0%
Marital Status		
Single	9	100.0%
Married		
Widowed		
Divorced		
Children		
None	9	100.0%
One		
Two or more		
State/County of Permanent Residence		
Kansas, United States	9	100.0%
Place of Birth		
Kansas	5	55.6%
Missouri	3	33.3%
North Carolina	1	11.1%
Prior Education		
High School	5	55.6%
Some Vocational		
Associates Degree		
Bachelors Degree in Other Field	4	44.5%
Graduate degree in other field		

Employment		
No	1	
Yes	8	88.9%
Usual number of hours worked per week		
10-14 hours per week	2	22.2%
15-19 hours per week	2	22.2%
20-24 hours per week	3	33.3%
25+ hours per week	1	11.1%
Number of Trips Taken Outside of the United States*		
No trips	2	22.2%
1-2 trips	2	22.2%
3-4 trips	2	22.2%
5-6 trips	1	11.1%
7-8 trips	2	22.2%
Reason for trips taken outside of the United States*		
Vacation/holiday	6	66.7%
Missions work	1	11.1%
Military service		
Business travel		
Other	4	44.5%
Length of time spent outside of the United States*		
Average length of time		
Less than 1 week	1	11.1%
1 – 2 weeks	23	82.1%
3 – 4 weeks	1	11.1%
5 – 6 weeks	1	11.1%
7 – 8 weeks	1	11.1%
More than 9 weeks	1	11.1%
Source(s) of funding for immersion experience*		
Self/spouse	9	100.0%
Parents	5	55.6%
Other (e.g., scholarships)	6	66.7%
Proportion of trip that was self paid		
0%		
1-less than 25%	2	22.2%
50 – less than 75%	5	55.6%
75 – less than 99%	2	22.2%
100%		

* Participants could select more than one response.

Qualitative Content Analysis Process

Qualitative content analysis, a research method for establishing valid, reproducible inferences (Elo & Kyngas, 2007) was used to analyze the transcribed audio-tapes from the three focus groups conducted. The analysis process was both inductive and iterative in nature and began after the completion of the first two focus groups conducted in the pre-immersion stage, and continued until all data was collected. Analysis was systematic and thorough utilizing an inductive content analysis process because of the interest in discovering themes and patterns in the data (Patton, 2002).

All focus groups were audio-taped and transcribed verbatim by a professional transcriptionist as soon as possible after the interviews. A research assistant took notes during each of the focus groups that were compared and validated with the transcripts. Once the transcriptions were complete, the researcher listened to the recordings while reading each transcript to validate and clarify the content included in the transcriptions. This helped ensure accuracy of the transcription process (Patton, 2002). Each transcript was read again in order to gain a comprehensive perspective on what participants were saying. The researcher began the coding process on the second reading of the transcript by developing detailed coding sheets for each focus group transcription following the examples illustrated in Graneheim and Lundman's (2004) article.

More specifically, the researcher began analyzing data after the second reading of the transcripts from the first focus group conducted in the pre-immersion phase. Detailed coding sheets were developed. The unit of analysis was the text of the focus group transcript as well as observations made during the focus group. The meaning of the text (latent content) was the focal point of the content analysis in that the text was used to interpret relationships and the underlying

meaning of the global healthcare experience. The researcher was alert to and identified words and/or phrases that were similar and/or had the same central meaning. Meaning units were condensed further through the process of abstraction while retaining the broader description of the unit. Organization of this was done based on the interview questions asked in the focus group in an effort to maintain meaning and context of the coding/analysis.

At this point, the researcher began analysis of the second focus group conducted in the pre-immersion phase by following the same process outlined above. Once this step was completed, the two documents were merged into one. Although there was some variation among interview questions between each of the pre-immersion focus groups, the information was matched as closely as possible to maintain meaning and context of the analysis during this step. Codes were then used to label each condensed meaning unit in the new document and assisted the researcher in forming categories.

The cohesiveness of the coding provided the foundation for developing categories (Graneheim & Lundman, 2004). Patterns of meaning were identified from the categories that led to the development of overarching themes (Patton, 2002). As the researcher was immersed in the data, new questions arose following the same line of questioning which allowed the researcher to delve deeper into a relationship or underlying meaning which initial questions failed to reveal from the focus groups. Analysis was continued until data saturation was reached. Each step of the data analysis process for the pre-immersion focus groups was peer reviewed prior to review from the qualitative content expert faculty advisor. Insight and feedback from peer and the qualitative expert advisor was incorporated into the analysis. This portion of the analysis was completed prior to beginning data analysis on the post-immersion focus group.

The process outlined above for the first pre-immersion focus group was also utilized for the second pre-immersion and post-immersion focus group. Review of artifacts, informal interviews from student participants and course faculty, field notes, and participant observations are used to support findings in the pre- and post-immersion phases. Similarly, student reflective journals written during the immersion experience were utilized to support research findings as well. Student reflective journals followed a standard format set forth by the course faculty. Questions for required student journaling can be found in Appendix G. Insight and observations of the aforementioned sources of data are integrated throughout the research findings as appropriate. Member checking for the purposes of this study was done via clarification of information during each of the focus groups, review of information from student reflective journals, and the researcher's analytic audit trail that was done to validate information.

Trustworthiness and Methodological Rigor

Trustworthiness and methodological rigor were established according to Lincoln and Guba's (1985) framework of credibility, transferability, dependability, and confirmability. Issues of authenticity were also addressed (Guba & Lincoln, 1989).

Triangulation of data from using multiple data collection methods such as participant observation, focus group interviews, field notes, informal interviews with student participants and course faculty, documents and artifacts (such as course syllabus, required student reflective journals) along with collection and analysis of data until saturation was achieved support credibility. This also ensured that alternative variations in the data were examined. Moreover, since the researcher collected and analyzed all of the data, credibility is maintained through extended engagement as well. Finally, credibility is further established through the integration

of participant quotes from each of the three focus groups into the analysis and reporting of the data. This helps provide the thick, rich description desired in qualitative research (Patton, 2002).

Objective, peer debriefing with a PhD colleague occurred during each step of the analysis phase as well as regular (e.g., monthly) debriefing with the faculty research advisor during the analysis phase with the intent of investigating other potential meanings evident in the data, clarification of the analysis process as needed, as well as interpretation of the findings. This strengthened the rigor of the study and helped reduce possible bias influence. Clarification of responses as well as opportunity to include additional information at the end of each focus group meeting served as a means of member checking.

Collection of information-rich data was completed during participant observations and focus group interviews which will lead to transferability of findings. An audit trail was established with documentation of faculty advising and reflexive journaling by the researcher which included thoughts and experiences pertinent to the research topic (e.g., notes written from informal interviews with students and faculty instructors). In addition, the researcher documented pre-conceived ideas about the global healthcare immersion experience prior to the beginning of data collection. In this way, dependability and confirmability are further supported (Lincoln & Guba, 1985; Patton, 2002).

In order to establish authenticity, the principle of fairness was included in the analysis phase primarily because data are value-bound. Therefore, different constructions of the data were presented, checked, and clarified in an unbiased way, particularly to evaluate if underlying values were in conflict (Guba & Lincoln, 1989). Identification of stake-holders (e. g., University SoN, SoN course faculty, and member checking (e.g., student participants) throughout the data analysis are techniques which were used to help establish authenticity

Ethical Considerations

Participant's personal identity was maintained by using pseudonyms and when using quotes. Audio-recordings and transcriptions of files were sent electronically via a secure file link. Transcripts are being maintained in a secure file at the School of Nursing as required by the research review board and then destroyed.

In addition, the researcher is aware that the use of qualitative descriptive techniques such as participant observations and informal interviews may raise ethical concerns. Relationships used in gaining access to the setting may be exploited; participants may view the research techniques as an invasion of privacy; and the researcher may have limited control over the research process, are all examples that may raise ethical concerns (Baillie, 1995).

Summary

In this section, the design of the proposed study was described. An overview of the sample was given along with the course description, support and rationale for sample size, and inclusion/exclusion criteria. Information pertaining to the setting was provided and includes a brief overview of the academic setting, host organization, and global location. Data collection methods were detailed as well as content analysis methods. A special section on human subject consideration is included as well. Methodological rigor and trustworthiness, and ethical considerations of the proposed study were given.

Chapter Four

Results

The results of the study are presented in this chapter. Organization of the findings will occur as follows: (a) results of Phase I: Pre-immersion, (b) results of Phase II: Immersion or cultural interface, and (c) results of Phase III: Post-immersion. Information from course documents, observations, informal discussion with faculty and students, student reflective journals are incorporated throughout the findings as appropriate. See *Table 4* for a complete list of themes and categories in each phase of the data analysis.

Table 4

List of Themes and Categories

Results of Phase One: Pre-Immersion

Theme 1: Using Personal Strengths and Desires to Help Move Past Barriers in Preparation for Global Immersion Experiences

- Desire to travel abroad
- Prospects for traveling abroad
- Family involvement
- Practical tips, guidelines, and strategies
- Perceived personal challenges to studying abroad

Theme 2: Garnering an Understanding in Completing Academic and Personal Requirements in Preparation for a Global Immersion Experience

- Flexible attitude
- Learning independence
- Personal concerns
- Academic and clinical requirement challenges

Theme 3: Identifying Critical Faculty/Organizational Supports in Promoting a Successful Global Immersion Experience

- Perceptions of sending organization
- Perceived lack of planning by receiving organization
- Interactions with mentors/key people

Theme 4: Moving Through Early Stages/Phases of Cultural Competence in Preparation for Global Immersion Experiences

- Becoming culturally aware
- Cultural skills and nursing
- Perceived benefits of study abroad experiences

Results of Phase Two: Immersion or Cultural Interface

Results of Phase Three: Post-Immersion

Theme 1: Reflections on the Usefulness/Benefits of Pre-Immersion Activities and Behaviors in Preparing for the Immersion Experience

- Character traits and attributes
- Developing relationships with primary key persons
- Acquisition of travel advice and tips
- Stressors related to academic requirements

Theme 2: Acknowledging and Identifying Cultural and Other Stressors in Order to Have Meaningful Clinical and Personal Experiences During a Global Immersion Experience

- Moving through stages of cultural understanding
- Communication barriers regarding clinical experiences
- Stressors related to academic requirements while abroad
- Developing relationships with secondary key persons (e.g., other students, international travelers, and locals)
- Positive mentoring by health care providers
- Experiences in the clinical setting/patient care experiences

Theme 3: Moving Past Re-entry Adjustment in Seeking Meaningful Reflection of the Personal and Professional Impact of the Immersion Experience

- Re-entry fatigue and adjustment aids
- Academic and professional demands in re-entry period
- Reflections from personal perspective

Theme 4: Restructuring Organizational Processes and Academic Programs Needed in Order to Ensure Success of Future Global Immersion Programs

- International resource person(s)
- Concerns and ideas regarding immersion experience
- Length of immersion experience and suggestions for change

Results of Phase One: Pre-Immersion

The results of this section are organized in such a way as to tell the story of the participants' journey through the global healthcare immersion experience in the pre-immersion phase. In other words, the placement of each theme as well as the order of each category within the theme is purposively placed in an effort for the results (e.g., the story-telling) to be sequential and logical.

Four overarching themes were identified from the data analyses of the pre-immersion focus groups. The themes are as follows: (a) *Using personal strengths and desires to help move past barriers in preparation for global immersion experiences*; (b) *Garnering an understanding in completing academic and personal requirements in preparation for a global immersion experience*; (c) *Identifying critical faculty/organizational supports in promoting a successful global immersion experience*; and (d) *Moving through early stages/phases of cultural competence in preparation for global immersion experiences*. Each theme and supporting categories is discussed below in more detail.

Theme 1: Using Personal Strengths and Desires to Help Move Past Barriers in Preparation for Global Immersion Experiences

There are five categories in this theme including the following: (a) desire to travel abroad; (b) prospects for traveling abroad; (c) family involvement; (d) practical tips, guidelines, and strategies, and; (e) perceived personal challenges to studying abroad. Each category will be described utilizing participant quotes to help illustrate the meaning of each category.

Desire to travel abroad. The desire to travel abroad was the impetus for participants to be involved in a global healthcare immersion experience. In some cases, this desire stemmed from past travel experiences such as the participant who stated that she went "...to Mexico for

spring break... and I went on the two week trip to Europe and I went through Germany and Austria and Northern Italy, but I've never really been to a developing country." Regardless of past travel abroad experience, all participants shared alike their expressed desire for an opportunity to travel abroad. One participant expressed interest in traveling whenever there was opportunity to do so whereas two other participants greatly desired to travel abroad for the first time. Furthermore, participants primarily viewed their past travel experiences positively as illustrated by this participant's comment, "...any like exposure I can get to developing countries, it just really it just builds me as a person...has been just like the best experiences in my life."

Prospects for traveling abroad. Desire to travel abroad is one element to consider in preparing for a global immersion experience; having prospects for traveling abroad is another matter. For several participants, the potential to participate in a travel abroad experience was a critical element when choosing a nursing program. One participant said, "I didn't think I'd be going to nursing school, but when I figured out that I was going to, I looked for a program that would allow me to travel abroad," while another specifically commented that her reason for choosing the University was the option of participating in the study abroad program. Several other participants nodded their heads in agreement to these comments. Several participants commented on how the prerequisite nursing courses limited their ability to go abroad related to sequencing of courses as well as the strict pre-requisite schedule. However, participants recognized the unique opportunity they have at the University to be involved in nursing in an international setting. This participant's comment summarized the group sentiment, "I think we're all pretty privileged to be going abroad....I don't think any other nursing programs, at least within the city, send people abroad and I think it's kind of a rare thing, so we were pretty lucky." Finally, participants recognized and acknowledged the value of having an opportunity to

participate in this type of experience from faculty instruction as well as through clinical experiences. Essentially, the importance of being culturally competent for patients and in future employment opportunities has been stressed in the context of course instruction.

Family involvement. Aspects of family involvement were seen primarily as expressions of concerns for participants traveling abroad as well as words and actions that were supportive in nature. All participants acknowledged various degrees of concerns and support from their family that was associated with their upcoming participation in the global healthcare immersion experience. One participant related this exchange with her parents while in the early stages of planning for the experience:

When I told them that I wanted to do this and that I was applying and I got to rank my top three countries, it was India and South Africa and my parents said no to South Africa.

And they were like; you're pushing it with India.

An array of words was used to describe families' unfolding reactions and emotions to participants' impending immersion experiences. Examples included the following: anxiety, nervousness, stressful, uncertainty, and worry, on one end of the spectrum and excited and supportive on the other end. Although parents' multiple text, email, and phone messages during the day or night were stressful for several participants, they also tried to maintain a positive spirit as noted by this participant's comment, "my parents are very supportive...but I think they're a lot more nervous than they let on, but they'll be okay."

In an effort to address concerns expressed by their families and therefore gain support for their global endeavors, participants have found effective ways to attend to these concerns. Participants provide examples of how they made itineraries for their families, communicated information pertaining to safety concerns, provided updated schedules, and set up Skype for

parents, to name a few. In addition, several participants reported that they had spent more time talking to their family members regularly updating them on what they had learned about their upcoming experience.

Practical tips, guidelines, and strategies. There are many details involved when preparing for global healthcare immersion experiences. Assembling financial aid, through scholarship monies or parental assistance was one such necessity discussed by several participants. Other essential requirements for all participants included completion of travel documents, application for travel visas, and obtaining vaccinations and/or medications. Applications for travel visas were completed by participants, but officially submitted by the University's international resource office. A couple participants expressed frustration with the process of how specific travel documents were expected to be completed, but yet were grateful for the assistance from the resource office. Vaccinations needed for travel differed depending on the country and included a variety of vaccinations/medications such as for yellow fever, Hepatitis A, typhoid, and malaria, for example. Another participant found the checklist from student health services helpful, but not the restrictions on walk-in appointments.

Practical tips and guidelines were available for all participants from a variety of sources. One participant received a packet of instructions from the physician coordinator detailing items needed for the experience including reading lists, assessment and diagnostic aids, as well as specific items to pack. Other participants reported they received a plethora of advice from former travel abroad students. Another participant was sent a list of medical supplies and equipment to bring such as a pair of goggles, a head lamp, and disposable gloves. Many participants utilized the notebooks detailing previous students' travel experiences that were accessible through the international resource office. Even with detailed packing lists, several

participants expressed uncertainty about what personal items (e.g., clothes, personal hygiene) should be packed and which ones they could buy abroad.

Perceived personal challenges to studying abroad. All participants felt there were big gaps in terms of their preparation for clinical experiences abroad. Furthermore, several participants were hesitant and anxious about what material they should review in preparation for the experience because of uncertainty about their roles and responsibilities as noted in the following comment, “I mean people keep asking us what we’re going to be doing in the hospital, we have no idea. Like I don’t know if we’re allowed to do anything because we’re on visitor Visas.” Other participants’ murmured agreement while nodding heads in approval with the above comments. Another participant was focused more on how effective her nursing skills would be while abroad:

What I’m actually really scared of or anxious about, is like how are my skills here actually going to translate to doing them there?...we’re only used to this kind of healthcare system, so maybe the things that I would suggest or how I would usually treat somebody isn’t even how they would do that. They might not be open to those types of treatments. So, I don’t know.

Others felt that it was hard to prepare because of the practice and communication differences with other countries. Anticipated differences in communication with the host country included differences in the country’s primary language (e.g., Spanish in Ecuador, Dutch in Amsterdam, and 11 national languages in South Africa) and differences in pronunciation of common words as noted by several participants traveling to English speaking countries such as Ireland and parts of South Africa. In addition, ongoing frustration related to written

communication efforts (e.g., slow responses to email and incomplete answers to questions) with host sites was commonly reported by several participants.

Theme 2: Garnering an Understanding in Completing Academic and Personal Requirements in Preparation for a Global Immersion Experience

Certain skills and characteristics are perceived as important for personal success in global immersion experiences. Identifying personal concerns regarding safety and health is essential. Personal characteristics (attributes) and attitudes such as independence along with confidence in one's abilities to succeed also are important and provide a sense of personal readiness. Preparation for academic and clinical requirements and responsibilities while abroad presents other challenges. This theme has four categories that will be described below: (a) flexible attitude, (b) learning independence, (c) personal concerns, and (d) academic and clinical requirement challenges.

Flexible attitude. Flexibility or adaptability was a distinguishing attribute that participants found helpful as they moved through this phase of their experience. Most often, this was described as being able to "...go with the flow" or the importance of having the right mindset. Although this attribute was noted during a variety of discussions, the one related to choice of country for the immersion experience stands out. For example, some participants gave specific suggestions with what they wanted (e.g., a country whose language was different than their own) but for others, final placement made no difference as noted in this comment, "I mean we picked our top three, but you could have scrambled them and it wouldn't have matter[ed] to me really." Furthermore, participants generally accepted the idea of flexibility in how they have dealt with situations in the past as well as their current expectations for the immersion experience. The following example illustrates this idea, "I think we'll all adjust pretty well. I

think we've all been thrown into some crazy situations before. So I think that's why we're going abroad too, we're like capable of adjusting well."

Learning independence. Adaptability was an important feature as participants gained hands-on experience learning independence. Although participants expected to be actively involved in the numerous tasks related to this experience (e.g., buying tickets, completing health checkups and receiving vaccinations, and submitting passports for visa requirements), they were surprised at how involved they were in the preparation phase. One participant in particular commented, "...I guess I just kind of thought oh since we're doing it through, you know, [the University] and everything that they had more of [a] hand in that."

Specific examples of tasks undertaken include the following: (a) finding new housing because of the house lady's changed health status, (b) making contacts abroad from a list of names received, and (c) dealing with cancelled flights that had been previously booked. Essentially, participants felt that they were on their own for much of what needed to be done. Nonetheless, completing these tasks contributed to participants' sense of excitement for the experience as evidenced by participants' smiles, tone of voice, and nods of affirmation. In addition, participants learned to be more self-reliant and independent or as one participant put it:

I think they're trying to make us realize that we're going to be over there by ourselves and we need to be able to plan all of this and get all this stuff here so that when we're over there we're confident enough to go out on our own.

Personal concerns. This category includes a variety of personal concerns ranging from fear of the unknown to health and safety concerns. Although several participants expressed a general fear of the unknown and issue with language barriers, others had concerns of how receptive people would be towards Americans. Personal health issues were also raised by

several participants. Although participants had been advised against eating fresh fruits or vegetables and drinking only bottled water, they were still concerned about being sick while abroad. Participants' traveling to South Africa had concerns about exposure to HIV/AIDS because of the numbers of people in Africa with this condition and their potential contact with blood from working in a trauma unit where this is typical.

Finally, participants' concerns regarding safety varied depending on where they were going for their immersion experience. A couple participants commented that the country of their immersion experience (e.g., Amsterdam and Ireland) was not much different than the USA and felt confident that their belongings would primarily be safe; whereas other conveyed concerns about their destination. For example, one participant said,

The crime rate is extremely high in Ecuador, so I've been trying to find like things that I can conceal in my clothes and like where to keep my goggles...in the city we're not going to have any place to put our valuables really...I can't bring my computer because I can't bring it to the Rain Forest, but if I were to leave it in town too it would probably get stolen.

Academic and clinical requirement challenges. Challenges faced by participants as they prepared for their immersion experience essentially fell into two broad areas: academic and clinical. Academic issues related specifically to course requirements at the University whereas concerns regarding clinical pertained to the immersion experience.

Participants identified the following stressors related to the academic requirements expected of them during their immersion experience: (a) changes in time zones and being able to post timely discussion board responses; (b) inaccessibility to a computer and/or good internet connections; (c) class modules not available for students until after their departure; (d) amount of

homework assignments (e.g., daily log, weekly journals, message boards, and discussion posts); and (e) difficulty in looking up information needed for clinical because of time spent doing required course work. Some students also contemplated taking a late penalty on assignments in an effort to help reduce stress. In addition, two participants traveling to South Africa had changes to their program dates which pushed back their departure, but yet assignment due dates were not changed. The following statement made by one participant captured the sentiment of the group as noted by nods of affirmation amidst murmurs of agreement:

I'm just stressed in general about the fact that we have to keep up with stuff while we're there. I think I'm just going to want to enjoy my time and we're going to have long days, you know, working in the hospitals and in the community, I'm not going to want to come back home, get on my internet connection that's not very good in the first place and have to submit some assignment. I think it's just going to seem very unimportant in comparison to what we're doing there. So it's going to be a challenge to motivate myself to do those things that are going to seem less important.

In spite of the stressors experienced, participants felt that at least some of the course faculty were trying to assist them by sending a list of assignments to complete while abroad. A variety of concerns were expressed by participants related to clinical experiences abroad. Participants traveling to India had specific concerns related to environmental features of the hospital (e.g., air conditioning/heat) and shift expectations (e.g., 8-hour or 12-hour shifts). However, performance of clinical skills in the immersion setting was an overriding concern for nearly everyone. One participant expressed concern about not having done a nursing-based clinical in a while. This participant went on to share,

I'm like praying that they don't expect a lot of us and they don't just like throw [us] in there...I need a slow immersion into the actual medical aspect, the nursing care. ...they haven't really told us a lot about our preceptors, so I don't know what that ... setup is or if they know English or am I following, do I get to do...I have no idea.

Theme 3: Identifying Critical Faculty/Organizational Supports in Promoting a Successful Global Immersion Experience

Facilitating positive student immersion experiences requires planning and preparation for the organization sending the students abroad as well as for the agencies receiving students. Ongoing communication within and among all parties involved is essential for success. Connecting with a key person who has had experience in planning and/or participating in a global immersion experience can be useful in successfully planning and preparing for the many details involved in global immersion experiences. Three categories comprise this theme: (a) perceptions of sending organization, (b) perceived lack of planning by receiving organization, and (c) interactions with mentors/key people.

Perceptions of sending organization. Although most participants had been abroad at least once, the combination of the length (e.g., ~4-weeks) and purpose (e.g., immersion experience/study abroad) of the trip was the first of its kind for all participants. Furthermore, this type of experience necessitated differences in the planning and preparation than what might be required for a holiday or vacation. For example, participants not only had to make personal preparations (e.g., setting up communication with families and determining what types of clothing and other personal belongings to take), but they also were handling the details of their experience while planning how to complete their academic requirements and follow the guidelines established by the University.

Participants were surprised and frustrated at what tasks they were required to do particularly with what they perceived as little to no assistance from staff/resources at the University. In addition, participants commented that general organization of the experience was lacking. This applied to the general structure of the immersion experience as well as to course faculty and assigned coursework. Participants definitely felt they were on their own figuring everything out as one participant stated,

I've never had to plan a trip by myself...the whole getting my plane tickets and contacting someone in a complete different time zone and trying to communicate with them about who's picking us up, when we need to be there, what we're going to be doing...but it was like go and do it and then come back with questions.

Participants liked the idea of making an itinerary that included experiences outside of clinical practice but felt instructions and assistance from the international resource office related to housing, transportation, and key people to contact abroad could have had greater clarity and organization.

From another perspective, participants had frustration with general communication of school assignments as well. In particular, one participant was certain her course instructor was unaware that she would be without a computer during her immersion experience. Another participant made this comment about coursework, "They've... given us like a list of dates...lectures that we're missing, readings that we need to catch up on...but they didn't really...adjust that for myself and the other nursing student, so our dates are all scrambled. In spite of the perceived lack of communication with faculty, participants made an effort to communicate with course faculty either in person or via email prior to leaving for their immersion experience.

Perceived lack of planning by receiving organization. Challenges also were experienced by participants related to the receiving or host organization abroad. Although there were specific concerns about clinical experiences, there also were issues pertaining to transportation, housing, and communication, in general. Clinically, participants were in doubt about the number of shifts they were to work per week (e.g., three or five), the shift hours (e.g., 8- or 12-hour shifts) and start times; who they would be working with (e.g., nurse preceptors, student nurses, and/or medical students); and the larger concern regarding what they would be doing or allowed to do from a hands-on, clinical perspective. Participants not only had vague information about what they would be allowed to do, they also were aware of practice differences and clinical skill level between them and their host country counter-parts. Illustration of this is noted by the following comment, “I think we’ve learned more than they do at the point that they’re at right now, so they look to us sometimes for what to do, like the answers and stuff.”

Participants also expressed concerns related to host country differences in planning and scheduling. Furthermore, participants also recognized the challenges of working out the details of their stay abroad as noted in comments about transportation and making connections with key nursing personnel abroad. Finally, participants also were expected to find their own housing and trust that what they found would be okay. Only one participant had a detailed itinerary for what to expect each week.

Interactions with mentors/key people. In the midst of the perceived lack of planning and disorganization with both the University sponsoring the experience and the host/receiving agency participants made connections and had interactions with key people who were supportive in a variety of ways. Based on participant comments and descriptions, a key person was depicted

as a person providing tangible (e.g., tips, detailed packing lists) and/or intangible (e.g., providing moral support and encouragement) help. Examples of key people identified by participants include the following: nursing and medical students who previously went abroad, students (e.g., medical and physical/occupational therapy students) preparing for an immersion experience through the University, peers traveling together, physicians involved in the immersion experience, and the primary contact person in the international resource office.

In particular, participants traveling to India had the opportunity to meet with others who had gone as well as the physician sponsor for the India scholarship program. Other participants spoke of how lucky they were to have met with students who were willing to share their experiences in previous years. Another participant spoke positively about the aids (e.g., notebooks with others' experiences and suggestions) available to them through the international resource office. Also of importance to most participants was the chance to travel abroad with peers as illustrated by this comment, "...I'm definitely glad that I'm going with other students. I think that just...just being able to share that unknown experience with someone else kind of relieves the anxiety a little bit." All but one participant was traveling with at least one other peer. The participant essentially traveling alone had limited success in connecting with other medical students also traveling to the same location. The participant commented that it would have been nice to have made this connection.

Theme 4: Moving Through Early Stages/Phases of Cultural Competence in Preparation for Global Immersion Experiences

Cultural competence is desired for healthcare professionals at all levels of expertise. It is a process one can learn through a variety of ways. Awareness of and participation with local area or global diversity is one such method; total immersion into a culture different than one's

own is another way of learning cultural competence. It is useful to have and utilize a multi-faceted approach (e.g., sense of humor, use of observations, and how to acquire knowledge) in the process of adapting to another culture. Learning to be culturally competent can also begin with and include a person's desire to give back and/or help others. In addition, language skill acquisition, improved clinical skills, and changed worldviews are some of the perceived benefits of participating in this type of experience. This theme has three categories: (a) becoming culturally aware, (b) cultural skills and nursing, and (c) perceived benefits of study abroad experience.

Becoming culturally aware. In their journey to become culturally aware, participants provided a number of examples of how this occurred. For one participant, attending the international fair sponsored by the University and interacting with student presenters was beneficial. A number of participants talked about how their experiences as students in clinical settings increased their awareness of cultural differences as evidenced by this participant's comment, "It's been very eye opening seeing...different ethnicities and cultures just in the hospital....I definitely have had patients that didn't speak English...I had...a Burmese patient once who was literally all hand gestures and zero English." Other participants spoke about specific experiences in their coursework such as working with refugees that represented at least seven different cultural groups. Whereas another participant spoke of how reading the *Spirit Catches Us When We Fall Down* was a good example of the assumptions people make about others. In addition, a couple participants received books from family members on the country of their immersion whereas another participant reported the following:

Ever since I've realized I was going to India I started paying attention more to what's going on over there....I think I'm a lot more aware that India has things going on and it's

in the news a lot more than I thought it was kind of thing...I've started to try and look at the area that we're going to and like what kind of things go on there, like the main religions and how big it is.

Cultural skills and nursing. Although participants have demonstrated an understanding of cultural issues, they also have expressed a desire for cultural skills specifically in nursing. Participants recognize that working with patients from other cultures can be exhausting and tiring particularly when communication is challenging, extra time is needed to process the meaning of the situation, and multiple methods are necessary (e.g., use of hand gestures, reiteration of instructions, and utilization of interpreters). Participants expressed a desire to have greater understanding of what other cultural groups experience when they come to the USA. One participant described a clinical situation that involved a young Burmese family whose infant child was hospitalized. Through caring for this child and watching the nurses around her, this participant began to realize the importance of developing cultural skills particularly in nursing. She went on to share the following:

I was...sitting at my desk and I was just like they do not understand what we're doing and why we're doing it. And I heard one of the nurses say it doesn't matter, they don't speak English anyway a couple of times and...I mean I've watched nurses get really frustrated with people of different backgrounds and with different beliefs and kind of not be rude, but like put them in a room where they don't have to deal with them.

Perceived benefits of study abroad experiences. It was easy for participants to identify perceived benefits of a global healthcare immersion experience. The range of benefits varied and included language skill acquisition, being able to help/give back, clinical skill development, cultural awareness, as well as changed perspectives. One participant specifically wanted to

improve her Spanish language skills and therefore chose a country where this would be possible. In addition, part of the experience also included structured opportunities to enhance acquisition of the Spanish language. Several participants talked about their desire to give back. Clinical skill development was also at the top of the list of perceived benefits. Participants were not only looking for hands-on experiences such as working in a trauma unit, but developing their critical thinking skills without the use of technology as illustrated in this participant's comment, "I wanted to go to a place...where the reliance on technology for diagnosing was a lot more limited, so that you can't just give everyone an MRI, you have to have some other clinical judgments before that happens."

Participants easily identified characteristics deemed important in the adaptation process such as: (a) maintaining a sense of humor; (b) setting aside personal expectations; (c) being respectful, flexible, and open to new situations; (d) allowing oneself time to adjust to a new culture and a new environment; and (e) "...knowing what questions to ask somebody from another culture...that wouldn't come off as offensive." Although most participants thought that there were good immersion experiences locally that would help them with cultural adaptation, others felt it would not be the same type of experience as being immersed abroad. It is important to note that all participants' first choice and/or priority were to have an immersion experience abroad.

Lastly, participants hoped for and expected a changed perspective or worldview. One participant felt it was beneficial that the majority of them would have the feeling of what it was like to be different (e.g., a minority) because of where they were going to be located (e.g., Ecuador, India, and South Africa). Some participants desired to have a broader understanding of

the healthcare system and healthcare policy in comparison to the USA whereas others were more general and wanted to “...get in there and get a better world view.”

Results of Phase Two: Immersion or Cultural Interface

Data collected in this phase of the research study, specifically student reflective journals (See Appendix G), were not analyzed in the same way as the focus group transcripts (e.g., development of detailed coding sheets). Instead, all the data including the journals, information from informal interviews with course faculty, and field notes, were treated as artifacts and/or observations and were therefore incorporated into the results section of Phase Three. Feedback from the faculty advisor led to this decision and was deemed appropriate because it was not feasible for the researcher to travel with each of the participants to their respective immersion destinations.

Results of Phase Three: Post-Immersion

Four overarching themes were identified from the data analysis of the post-immersion focus group as well. The resultant themes are specifically organized in order to best capture participants' descriptions of their collective experiences. For example, in Theme 1 participants reflect back solely on their pre-immersion activities whereas Theme 2 essentially relates to participants' immersion or cultural interface experiences. Theme 3 centers on the immediate re-entry phase while Theme 4 looks toward future global immersion experiences. The order in which categories are described within each theme is again purposeful.

The themes are as follows: (a) *Reflections on the usefulness/benefits of pre-immersion activities and behaviors in preparing for the immersion experience*; (b) *Acknowledging and identifying cultural and other stressors in order to have meaningful clinical and personal experiences during a global immersion experience*; (c) *Moving past re-entry adjustment in*

seeking meaningful reflection of the personal and professional impact of the immersion experience; and (d) Restructuring organizational processes and academic programs needed in order to ensure success of future global immersion programs. Each theme and corresponding categories are discussed below in more detail.

Theme 1: Reflections on the Usefulness/Benefits of Pre-Immersion Activities and Behaviors in Preparing for the Immersion Experience

Review of activities that occurred in the pre-immersion time period primarily focus on acquisition of travel advice and tips and developing relationships with key persons who were utilized for information and support. A variety of sources were utilized to acquire advice and tips on participants' scheduled travels and included use of the internet and aspects of academic course work. Interactions (e.g., group, individual, and electronic) with key persons provided an opportunity to develop relationships with previous students, physicians involved in the experience, and the international resource office personnel. Although mandatory academic requirements scheduled at the beginning of the course semester were cited as a source of frustration, flexibility and open-mindedness were recognized as key attributes for participants of immersion-type experiences. There are four categories to this theme: (a) character traits and attributes, (b) developing relationship with primary key persons, (c) acquisition of travel advice and tips, and (d) stressors related to academic requirements.

Character traits and attributes. As participants reflected on what character traits and attributes helped them the most, they spoke quickly about how "...going with the flow" was a ingredient for them. Several participants talked about how they would not have considered going on such a trip if they had not been flexible. In addition, participants also commented that they would not be able to complete an immersion experience without this attribute. Furthermore,

a number of participants spoke of how the excitement of planning for this study abroad experience was motivating. Finally, several participants stressed the importance of maintaining an open mind as noted by the following comment, “I feel like just being open minded to what was going on because...I could have imagined any scenario, but it just seemed like...not being prepared for whatever was going to happen. That was the best thing for me.”

These characteristics and attributes were carried into the immersion experience as evidenced by entries made in a number of student journals. For example several participants noted that open-mindedness and flexibility were skills used in addressing cultural challenges/issues. Student reflective journals followed a standard format set forth by the course faculty. Questions for required student journaling can be found in Appendix G. Other participants commented that these attributes were helpful in dealing with (a) last minute housing changes, (b) transportation issues such as times of waiting for a bus and/or being dropped off at a different location each day, and (c) clinical situations, by not helping them with “...not getting angry or upset.”

Developing relationships with primary key persons. Several participants spoke of key persons who assisted them to prepare for the immersion experience. Based on participant comments, a key person was described as someone who provided tangible (e.g., checklists) and/or intangible (e.g., encouragement) assistance during the process of preparation for the study abroad experience. For example, key persons included students (e.g., nursing, occupational and physical therapy, and medical students) who previously participated in University sponsored immersion experiences one and two years prior to the current year’s trip. Developing relationships with these students encouraged participants in their global healthcare endeavors as evidenced by this comment, “...it was really helpful just to kind of see how much they loved it

too. It's like I was really excited to go.” More specifically, the connections participants were able to make with the physician actively involved in the immersion experience in India were invaluable. All of the participants traveling to India were in agreement as noted by their expressions of approval, that the opportunities to gather together with other students prior to and after the experience were well worth it. Student reflective journals also affirmed this physician's presence onsite at the clinical agency in India. Some participants desired to touch base with others who had previously traveled abroad, but were unsuccessful in their attempts. However, a substitute to meeting students who had previously gone abroad was having the opportunity to read the binders (one for every country) created and organized by the international resource office personnel.

Acquisition of travel advice and tips. Participants provided insight about how they acquired travel advice and tips and from what resources. In addition, information was shared as to what did not work well for them in preparing for the immersion experience. A number of resources were utilized to provide participants with travel advice. Useful tips came from the relationships developed with key people as noted by this participant's comment, “they gave us a lot of cultural tips on what we might expect so that when we saw some things we weren't really shocked, like eating with their hands.” Other participants' were in agreement with the above comment as noted by their nods of approval and expressions of agreement.

The internet was utilized by several participants to look up information about their country of immersion and its healthcare system. Participants traveling to South Africa found their own research done by using the internet and YouTube, in particular helpful as illustrated below:

I watched a couple of videos on the trauma areas and Baraguana Hospital and just kind of got a feel....So I knew before we weren't going to the middle of nowhere, we were going to...a pretty big city and I had an idea of just demographics of the population and 11 national languages and all sorts of stuff about South Africa.

Another key resource utilized by participants was the country-specific *Lonely Planet* guidebooks. Several participants commented that they, "...lived by them." Information was available on a variety of topics, particularly activities that could be done outside of clinical requirements. Participants also spoke of previous coursework that was helpful such as the population course, work with refugees, and prior interest in public health.

Preparation activities that were less constructive included not doing "...that much to prepare because I just really wanted to go into it with an open mind, so I didn't really want to try and figure out what it was going to be like." In addition, participants did not find it helpful to attend some of the required class sessions for their study-abroad practicum that were designed as preparation for their experiences. This was because they felt like they already understood the values of importance to an immersion experience. A couple participants did not recall the class sessions.

Stressors related to academic requirements. Several stressors were present related to academic and University requirements for immersion program participants. For example, participants were required to begin the spring semester even though this meant that they would only be in class a few days prior to when they would depart for their immersion experiences. All participants expressed frustration about not being able to leave for the immersion experience over the winter break as evidenced by nods of approval. Participants were uncertain regarding all of the reasons behind this particular directive. Frustration also was experienced because

participants were required to attend class on Monday in order to take a practice exam for their National Council Licensure Examination (NCLEX) predictor exam that had to be proctored. This was schedule the day before they left for their trip and that course professors were “...adamant that we could not miss that one day class.” Email communication from the course instructor confirmed the scheduled exam (J. Greischer-Billiard, personal communication, January 21, 2012). In addition, activities were planned for their leadership course as noted in the course syllabus. Participants sensed that they were held back from booking flights earlier related to their ability to complete the required coursework as stated in this comment, “...I mean we made up four weeks, we could have made that up.”

Theme 2: Acknowledging and Identifying Cultural and Other Stressors in Order to Have Meaningful Clinical and Personal Experiences During a Global Immersion Experience

Familiar activities and situations encountered when immersed in a country different than one's own will often seem more stressful than how they are normally experienced. Cultural differences such as language, communication, time changes, and physical attributes can contribute to what is known as culture shock. Completing required course assignments and homework can add to the stress experienced while abroad. Adjusting to cultural differences takes time and effort. Personal reflection such as journaling and debriefing as well as developing relationships with others (e.g., students, international travelers) are avenues for adjusting and thereby increasing one's opportunity to get the most from cultural and clinical experiences. There was a range of experiences pertaining to clinical such as communication challenges with clinical preceptors and lack of clarity regarding roles and responsibilities in the clinical setting. Other experiences included connecting with other health care providers who could provide mentoring in clinical situations; having opportunities to learn about the health care delivery

system, and; providing hands-on care for patients. There are six categories in this theme: (a) moving through stages of cultural understanding; (b) communication barriers regarding clinical experiences; (c).stressors related to academic requirements while abroad; (d) developing relationships with secondary key persons (e.g., other students, international travelers, and locals); (e) positive mentoring by healthcare providers; and (f) experiences in the clinical setting/patient care experiences.

Moving through stages of cultural understanding. This category addresses how participants moved through stages of cultural understanding such as culture shock, awareness of cultural differences, and how they adjusted and coped. As participants arrived to their study abroad destinations, they began to deal with a wide variety of emotions typical of immersion experiences. Participants reported being “...overwhelmed”, surprised by the language barrier, and feeling awkward at being stared at and/or talked about because of being different than citizens of the host country. Student reflective journals were rich with similar descriptions, specifically noted in the first journals written within days of their arrival to their destinations. One participant found the newness of the Dutch culture “...eye opening.” Another participant reported on the stressful driving conditions in India. There also was surprise at cultural differences in countries similar to the USA, such as Ireland. Most participants felt there was no way to be prepared. Even though this participant was speaking of her experience in India, her description sums up how many participants felt, “Orientation to new culture—I feel like there are no words to describe what living in India is like. Each day is crazier than the next. Just when you think you’ve seen it all, you haven’t.”

After the initial shock of their first few days abroad, participants began to adjust to their new culture as they settled into a routine. Again, student journals provided great examples of

how recognition and acceptance of cultural differences helped them deal with the challenges they faced. Multiple examples were given such as how one participant learned local terminology for directions in Ireland and another began to understand the meaning of body language in Amsterdam. Several participants found adjusting to another culture easier than expected as noted by this comment: “there are many different nuances and distinctions in Tamil/Southern Indian culture...but it hasn’t been too difficult to get used to.” One participant had physiological (headaches) adjustment issues related to altitude changes as noted in her student journal.

Although some difficulty adjusting during the immersion experience was expressed by participants, this was the exception rather than the rule. However, it was interesting to note that one student had her personal belongings stolen (e.g., purse, apartment keys, passport, and method of payment) shortly after arrival to her destination; this “...posed significant stress”; others were staying in a gated community close to a dangerous part of the city. One participant had a 15 pound unplanned weight loss while abroad as noted in a faculty debriefing session. Observation of another student (not part of the study) in a debriefing session included a lengthy discourse of the challenges and difficulties she faced while abroad. Interestingly, this student identified a visit to a famous tourist destination (stated on her poster presentation) as her most significant experience as compared to two other participants who recounted a life-altering experience that involved a teen-age girl who died from multiple injuries sustained in a motor vehicle accident. Generally speaking, participants reported greater adjustment as time passed but also that it did “...not mean that there isn’t something that surprises me every day or makes me go, ‘WOW!’”

A number of techniques and methods were utilized by participants to help them through the challenges of these experiences. Although this was discussed in the post-immersion focus

group, the journals provided much support. One participant faced with the challenge of being stared at shared her method of dealing with it as noted in this comment, "...I just smile at them and people smile back most of the time." Other participants improved their communication skills by using senses such as active listening, and learning a few phrases in the local language or practicing language skills with a host family. Attributes such as patience, flexibility, having a sense of humor, and open-mindedness were also employed by participants. Many participants found reflective journaling helpful, but did not always have time to do this. However, all participants without fail discussed the importance and significance of debriefing daily with others (e.g., participants, other students from the University, international students also staying at the same hostel, friends and acquaintances made while abroad). Essentially, debriefing occurred via commutes to and from the hospitals/clinics, over dinner and/or drinks, or during times relaxing at the hostel where they were staying.

Communication barriers regarding clinical experiences. The challenges participants faced in communicating with preceptors and other clinical contacts abroad in the pre-immersion phase continued into the first portion of participants' immersion experiences. Information was gleaned from focus groups and student reflective journals. All participants experienced challenges in this area in varying degrees as there was a fair amount of confusion reported. For example, one site thought the students were coming later (e.g., the following week) whereas another site had expected participants the previous week. A couple participants reported being reprimanded for not being at their clinical site when expected. Other participants did not have a preceptor and just showed up for work whereas a few others were handed off from one preceptor to another for the first few days. However, a few participants were successfully connected to a preceptor. The participants traveling to South Africa seemed to have the most difficulty

connecting with their preceptors as noted in this exchange, “we were wandering around the first...week...because our contacts were not really very good either and one of our contacts had a family death or a couple family death[s], so she was not there to hook us up with anyone.”

Once participants in South Africa found a preceptor, their challenges were not completely resolved based on the continued struggle they had when changing clinic sites from one hospital to another one in the city.

Participants had a number of issues related to housing that needed to be worked out before they could realistically begin clinical experiences. Examples included misunderstanding and miscommunication with the hostel manager who did not speak English; housing that was inconvenient, or lacked privacy; and a housing lease that did not go into effect for several days after participants arrived in country.

Stressors related to academic requirements while abroad. Completing academic requirements while abroad and in conjunction with adjusting to a new culture, working out housing issues, and trying to get started in clinical experiences was stressful for all participants. Most of participants’ reported that their downtime was filled with completing course assignments. Overall, participants desire to keep up with course assignments took precedence over other activities. In addition, this participant’s comment about the time it took to complete assignments is worth noting: “I wish we would have been able to build more relationships with the people we met there....we didn’t have time to like really develop as...strong a relationship with the people that we wanted to.”

Participants reported how stressed they felt regarding the amount of assignments they were required to submit that included weekly journals, discussion board responses, and international practicum journals. In addition, several students also were required to review

research articles as noted by their completed assignments attached to the end of their journal entries. Review of the syllabi for the leadership course and international practicum provided verification of homework assignments for these two courses. One participant found her lack of internet accessibility "...[a] constant challenge to getting homework completed" as noted in her weekly journal. In addition, she had all of her assignments to do when she arrived back home because of this. Participants commented about how other international students they met abroad were surprised by the number of course assignments they had due. Interestingly, participants reported one faculty member (outside of the practicum faculty) worked with their circumstances in terms of due dates.

Developing relationships with secondary key persons (e.g., other students, international travelers, and locals). In spite of the aforementioned challenges participants faced, most participants were able to develop positive relationships with key people such as other students, international travelers, and locals. A key person is identified as someone providing tangible (e.g., tips and phone cards) and/or intangible (e.g., providing various types of support and/or encouragement) help in the immersion phases of the experience. One participant reported utilizing people resources to clarify vague information where others felt fortunate to have stayed with other international travelers in the hostel because they were able to learn the location and schedule for local buses. Participants reported how helpful connections were found through word of mouth and spoke of how being with other international students was great, particularly when they were able to travel together during their time away from their clinical responsibilities. In contrast, participants who traveled to South Africa felt somewhat isolated because they were living in a "...gated community...two blocks away from like the worst part of Johannesburg"; experienced challenges in simple tasks such as finding directions to the grocery store; hoped for

someone who would have taken a special interest in them, and/or had been with other students similar to the group who traveled to India.

Several participants were able to connect with local people. The participants who traveled to India had opportunity to share a meal with a local family in their home. Participants also related experiences with local families in their reflective journals. For example, the participant traveling to Ecuador stayed with a host family for a few days whereas another participant shared this story, “We had to stay with the director of international affairs at the hospital until our lease started. That was a unique experience because we were welcomed into a strangers home and she provided us food and shelter.” Overall, participants described these encounters as life-changing.

Positive mentoring by healthcare providers. After working through initial communication challenges with clinical agencies and staff, participants were able to experience positive mentoring by health care providers, primarily nurses, but also including student nurses, nurse managers, medical students, and physicians.

Participants were initially set up to work with nurse preceptors, some of whom were nurse managers with multiple responsibilities such as managing a unit while also teaching in the school of nursing abroad. The nurse managers in several settings granted permission and gave approval for schedule changes. Student reflective journals were rich with examples of mentoring moments regarding preceptors who regularly checked in on them and assisted with goal setting. Nursing students were helpful to participants in India, but less so to participants in South Africa primarily because of practice and skill level differences (e.g., nursing students primarily practiced taking vital signs). However, participants in South Africa worked closely with medical students and residents because their level of critical thinking and hands-on skill was more

comparable to their own. The participant who went to Ecuador had multiple interactions with the physician who was involved with this particular study abroad option; whereas the participants who went to India had less opportunity with the doctor involved in their experience. The two physicians (mentioned above) as well as the nurse preceptor for the participants in South Africa had lived abroad and in the USA for significant amounts of time (e.g., six months out of the year, several years, and/or 15 years). Participants who were immersed in these countries reported positive mentoring by these healthcare providers and felt fortunate to have interactions with them.

Experiences in the clinical setting/patient care experiences. All participants reported having good patient care and clinical experiences. Participant reflective journals had extensive notes about clinical experiences while abroad. For example, multiple interactions with patients and their families in a variety of clinical settings including Pediatric Intensive Care Unit (PICU), trauma, emergency room/department, and labor and delivery, rural and community health, and traditional medicine ceremonies were all reported. Along with this, participants spoke of the broad range of client diagnoses they were exposed to such as appendicitis, polydactyl, pneumonia, gunshot wounds, jaundice, attempted suicide, motor vehicle accidents, and viper bites, for example.

Participants were surprised at the gratefulness expressed by patients for their care and felt that overall, patients never complained. One example given was about "...a guy that had been stabbed in the eye, gotten morphine eight hours...previously and...was, yeah, fine. Hanging out." Participants appreciated the patient-centered care and learning to depend less on equipment and technology. Student journals provided numerous examples of specific contact with patients and their families noting the importance of communicating with and including family members

in on the decision making regarding a patient's care. In addition, participants noted many practice differences in the country of their immersion compared to the USA including increased efficiency by bundling care (e.g., doing all the care for a patient prior to caring for a second one); less waste (e.g., gloves were reused and patients paid for items such as medications up front); and differences in perspectives about medico-legal suits. This participant's comment illustrates the tenor of the group, "...I accomplished what I came here for and so much more than I thought I would-it's been an amazing experience."

Theme 3: Moving Past Re-entry Adjustment in Seeking Meaningful Reflection of the Personal and Professional Impact of the Immersion Experience

Returning to one's own country from an immersion experience requires a period of adjustment whether it is catching up on one's sleep or getting used to the pace of life again. It also generally means returning to one's usual routine such as academic and/or job responsibilities. Meeting the demands of school and/or work requires time and energy and is dealt with better after a time of re-adjustment. Aside from the physical aspect of adjusting to one's home culture, having the opportunity to reflect and identify the personal and professional impact of the immersion experience is equally as important. This theme has four categories: (a) re-entry fatigue and adjustment aids, (b) academic and professional demands in re-entry period; and (c) reflections from personal perspective; (d) professional and healthcare delivery system perspectives.

Re-entry fatigue and adjustment aids. Participants' arrival back to the USA varied similar to their departure dates. For example, the majority of participants returned the end of February whereas participants who traveled to South Africa came back closer to mid-March, yet prior to the University's spring break. Flight arrival times for some of the participants were late

evening/early night hours on a Saturday night prior to scheduled class sessions on Monday, but within guidelines given in course documents. Traveling across multiple time zones from host countries to home created the inevitable jet lag with participants reporting lack of motivation, and tiredness. Many participants spoke of how exhausted and stressed out they were primarily from changes in sleep schedules related to jet lag and the multiple priorities they faced upon their return home. For some participants, being home and “time...just time” were the most helpful for their adjustment during the re-entry phase. One participant spoke of how she and the other students who shared the immersion experience, regularly spent time together talking about their experiences whereas another one made this comment:

I’ve been trying to think about it and it was really hard coming back and adjusting, being thrown back into kind of fast paced, stressful, like trying to apply for jobs at the same time as catching up on school work that we had missed while we were gone and so I’m seriously sitting here trying to think like what’s helped me, but it’s been really hard and I think maybe just...I don’t know.

Academic and professional demands in re-entry period. Adjustment in the re-entry period was made more difficult because of the added stressors of academic and professional demands. Participants basically felt that they “hit the ground running” upon their arrival home. For many participants, there was an exam scheduled for one of their classes on the Monday after their late night return on Saturday. In addition, many participants had either scheduled job interviews that week or received calls from potential employers asking for interviews. One participant shared that she went on her job interview after being up for two full days. Not only were participants exhausted from jet lag, but also they expressed experiencing significant amounts of stress and frustration related to the multiple tasks requiring their time and attention as

illustrated by this participant's comment, "while I was gone...I remember seeing someone who had an interview in one of the positions I really wanted...I didn't even get to apply yet....I went to...panic mode, my computer...wouldn't work and I literally was...frantic...it was horrible."

Additional stress came from classmates asking if they were ready to take the NCLEX exam and that participants had started working in their local practicum experiences immediately upon their return from abroad. Several participants talked about how it took them several weeks to catch up because of all the assignments that were due. Although one participant expressed this sentiment, the others nodded in approval, "...every time I thought I caught up all of a sudden it was like oh my gosh, I haven't done this, I have this due next week, I still don't have a job." Participants described the first few weeks as being difficult and thought they would not be able to graduate because of the challenges they experienced keeping up with their assignments while balancing other priorities such as job hunting, and applying and preparing for their Board exam. Participants did speak positively of the one faculty who moved deadlines back for them in an effort to help them with assignments.

Reflections from personal perspective. Participants enthusiastically spoke of changed personal perspectives as noted by facial expressions, hand gestures, and tone of voices. Overall, participants described life-changing experiences that left them with an increased desire to give back in some way such as through international health opportunity. Another participant spoke of how the experience caused her to have greater appreciation for the opportunities she has in her own circumstances. Participants also talked about how meaningful it was to them to have interaction with local people abroad as it provided a changed perspective for how it felt to be of a different race and/or be a minority. Student reflective journals were rich with examples supporting the aforementioned items. Values also changed for some related to their family, view

on material items, and general ability to communicate better. Furthermore, the ability to deal with stressful situations better by maintaining perspective on the important versus trivial issues was reported as noted in several participants' comments as well as student reflective journals. Finally, this participant shared her perspective on the concept of cultural competence that was acknowledged by other participants' murmurs of agreement, "I feel like... cultural competency has been emphasized throughout our whole nursing career, but just...those words, like you don't really fully grasp what that means until like you're somewhere and you're the complete outsider."

Professional and healthcare delivery system perspectives. This category is comprised of participants' reflections from a professional perspective including their impressions related to the health care delivery system at home and abroad. The desire for future opportunities and experiences in international health were expressed by a number of participants. Reasons given for this interest chiefly included a desire to give back (from a healthcare perspective) and enlarge one's scope of practice. One participant spoke of her aspiration to go on for additional schooling as a means to be able to contribute more internationally. Participants also were glad for the chance to see healthcare systems different than their own and broaden their view of (a) socialized medicine, (b) healthcare reform at home, (c) sustainability of healthcare, and (d) public health policy and practices. One student talked about how her immersion experience helped her evaluate healthcare reform in the USA resulting in a changed perspective for where she wanted to work at present (e.g., type of hospital unit) and in the future (e.g., community health).

Participants' communication practices changes as well as they learned techniques and skills in this area. Examples include learning to be exact, reiterate instructions, and clarify questions. In addition, there was recognition of how medical terminology could easily contribute

to patients' confusion in healthcare settings, particularly when English was not their primary language. Furthermore, many participants related to this type of situation because of their own lack of understanding of the language while immersed in their host countries. This realization has helped participants to be more patient in their care giving as well as to focus, "... on the patient and what they're telling you...not just...verbally, but...physically what they're telling you."

Insight also was gained pertaining to healthcare costs and careful use of healthcare resources. In particular, several participants who traveled to India expressed how much more "...conscious about not being wasteful" they were because patients were required to pay for items such as medical supplies and medications upfront. Along with this, participants reported enhanced assessment skills primarily related to less dependence on technology and equipment and more focus on listening to the patient. Agreement from other participants was noted by their comments. Student reflective journals provided support for this as well with multiple examples given.

Theme 4: Restructuring Organizational Processes and Academic Programs Needed in Order to Ensure Success of Future Global Immersion Programs

Successful organization of global immersion experiences takes time, resources, and expertise. Use of an international resource person(s) and/or preceptors to provide the needed expertise for global immersion experiences would be invaluable to the success of such programs. In addition, development of and/or changes to an established global immersion experience in an academic program requires consideration of placement in the curriculum, type of course (e.g., elective or required), and practical and realistic requirements for participants (e.g., adjustment of deadlines for assignments, travel arrangements). This theme has three categories: (a)

international resource person(s), (b) concerns and ideas regarding immersion experiences, and (c) length of immersion experience and ideas for change.

International resource person(s). Although participants expressed some frustration regarding communication and organization of the trip, they unreservedly agreed that having a key person responsible for the study abroad program such as the international resource person they worked with was imperative for the success of future immersion experiences. Participants also were in one accord pertaining to the benefits this person brought to the study abroad program. Participants felt this person had key connections necessary for the program and that she was knowledgeable with how the program worked. Furthermore, participants felt that a primary role of the international resource person was as the chief communicator between all entities/stakeholders involved in the program (e.g., students, faculty in the School of Nursing, and physicians working with the University and the immersion location such as in India and Ecuador). The person was perceived as the primary organizer for the entire experience.

Participants expressed much concern about the continuation of this person's role and the resource office as a whole because they had heard that the position/office was being disbanded. A list of concerns about the future of the program was presented. For example, several participants verbalized concerns about human resources (HR) being in charge of the program suggesting that the gaps in communication between faculty and preceptors abroad would suffer and that future students would feel less prepared than they did. Primarily, participants felt that the new situation without a key international resource person would be much worse than what they had experienced and that the program would lack success.

Concerns and ideas regarding immersion experience. Participants had a variety of concerns and ideas regarding their immersion experience other than the aforementioned

information pertaining to a key resource person. Several areas were addressed and included communication, general organization of the immersion experience, and issues and ideas related to the curriculum. Participants mainly felt that there were huge gaps in the communication between nursing faculty/preceptors at home and abroad, but that training and education efforts were satisfactory. Participants were frustrated regarding how much they had to do on their own pertaining to making connections abroad as illustrated by these two comments that seemed to underscore the communication issues: "...they told us if we come up with any good contacts to let them know and they can correspond with them."

Feedback on the general organization of the experience focused primarily on the immersion locations such as India and Ecuador where a key person (e.g., physician) was involved. Participants who traveled to these locations provided positive feedback. For travelers to India, there were more upfront or pre-immersion connections and interactions organized by the physician with minimal contact during the actual immersion experience. The participant who traveled to Ecuador thought her experience was more organized than other experiences were because of the time and energies invested by the physicians involved at this particular location. Participants who did not travel to these locations thought that the overall experience (e.g., pre-immersion contacts, and organization of immersion experience) was likely related to the physicians' understanding of American values.

The study abroad experience was placed in the first half of the spring or final semester of the academic program for participants. Most participants felt that the timing or placement of the immersion experience at this place in the academic program was unfortunate because of the challenges related to other responsibilities and activities they were required to complete (e.g., NCLEX predictor exams, graduation and State Board of Nursing applications, completion of

their local practicum upon return from their study abroad experience, and job searching, to name a few). In addition, participants shared that they had wanted to travel over the Christmas break, not just for the sake of traveling, but in order to get started in their experience. Finally, participants were concerned about the curriculum change moving the study abroad experience from a practicum option to an elective and whether or not students would be able to have much hands-on experience in the future. Participants agreed that changing the course to an elective made sense and would be beneficial for future students.

Length of immersion experience and suggestions for change. At first, participants felt that the immersion experience was too long, but as they settled into the experience they wished for more time abroad. In addition, participants felt that only four weeks abroad placed too many time constraints on them whereas six or eight weeks would have been better. Overall, although some participants felt that a semester abroad would be best, they ultimately agreed that eight weeks would be an ideal length for a study abroad program. Some participants thought that adjusting to the culture would have been easier with a longer period of time abroad while all participants spoke of their desire to have been able to spend more time building relationships with locals, traveling around, sightseeing, and being able to participate in local events (e.g., attending a yoga class). Support of this was noted in student reflective journals as well.

Other than the length of the trip, participants offered some suggestions for change more specific to their coursework and the curriculum. Ideas included the following: (a) move deadline dates back for study abroad students particularly on their return; (b) incorporate a "...dead week" into the schedule after students return from abroad for re-adjusting (e.g., from jet-lag); (c) be able to work on assignments ahead of time to help decrease the stress of dealing with poor or no internet connections; (d) move the immersion experience to the summer (as in the new

curriculum) so students can focus on only the experience; and (e) keep the study abroad program at a place in the curriculum so students can benefit the most from their hands-on experience (e.g., this experience was more like a practicum for students).

Summary

The results of the data analysis were detailed in this chapter. The three phases of data collection was used to organize the results of the research. Specifically, findings were presented from Phase 1: Pre-immersion, Phase 2: Immersion or Cultural Interface, and Phase 3: Post-immersion.

Chapter 5

Discussion

Chapter Five will begin with the discussion/conclusions of the research study. This section will be further divided in an effort to provide clear dialogue. The research questions will be addressed first followed by a discussion of the theoretical relevance of Jeffrey's cultural competence and confidence (CCC) model (OJCCNH.org, 2013), utilized as the organizing framework. A summary of the research findings in relation to the existing body of literature will follow. Summary of new/key findings, implications for practice, limitations and strengths of the study, and ideas for future research will be included prior to a special section on researcher as instrument.

Research Questions

The aim of this study was to describe components considered most essential in designing a short-term global healthcare immersion experience for BSN students that will enhance professional development in nursing practice in the areas of cultural understanding and global awareness. The purpose of the study was achieved through detailed analysis of the data generated from the focus group interviews along with in-depth review of observations gathered during the study, including, but not limited to student reflective journals. Rich description of students' perceptions pertaining to different aspects of a global immersion experience was obtained. The four research questions were answered as follows.

Research Question 1: What is the student perception of his/her ability to perform in a global health setting in the preparation, cultural interface, and post-immersion stages? (Self-efficacy). Students' perceived ability to perform in a global health setting was multi-faceted and changed as they progressed through each phase of the immersion experience. It is

important to keep in mind that students' perception of their ability to perform included personal and professional perspectives. Students' past travel abroad experiences (described positively); their desire to participate in a global healthcare immersion experience; their newly acquired knowledge gleaned from self-study and contact with prior study abroad students; as well as their excitement, flexible attitudes, and growing independence gave them a measure of confidence in their ability to perform abroad in the pre-immersion phase. However, this confidence was duly moderated, but yet not stifled, by a generalized fear or apprehension of the unknown related to the experience; the timing of their last hospital-based clinical along with the many details that had to be worked out regarding travel plans, housing, communication, and academics.

The early portion of the cultural interface was fraught with difficulties related to housing; communication regarding clinical placements and final assignment of preceptors; as well as beginning experiences of culture shock. In spite of these challenges, students remained positive and described reliance on their flexibility and open-mindedness as means to help them succeed even in the most distressing of circumstances such as stolen personal belongings. As the aforementioned details were resolved, students were able to settle into a routine, build relationships with others, and establish opportunities for debriefing, all of which further enabled them to successfully function in their respective experiences. Upon returning home, students expressed empowerment from their accomplishment in achieving their goals from this study abroad experience. In addition, students felt impelled because of their positive experiences to not only encourage and support others to go, but conveyed a desire to be further involved in future global immersion opportunities.

Research Question 2: What is the student perception of the educational information including clinical training that is needed in the preparation, cultural interface, and post-

immersion stages of the global health experience? (Cognitive/Practical). Students' perceptions of the educational information including clinical training needed for an immersion experience again varied. Educational information deemed important essentially included personal and professional (e.g., clinical) aspects of the following: practical knowledge, experiential learning, and reflective opportunities. In the pre-immersion phase, students were highly interested in learning practical information about their host country in general (e.g., demographics, health concerns, and cultural aspects), as well as details such as specific items to pack (e.g., medical supplies, personal hygiene items, and types of clothing needed), for example. Once abroad, this changed to deciphering the more complex cultural mores as well as interpreting transportation schedules, orienting to the clinic/hospital site, and learning key words and phrases in the local language(s) in order to better communicate. In the post-immersion phase, students' expressed how helpful the practical information gleaned in the pre-immersion phase from past travel abroad students and the international resource office was to them as well as the importance it held for future study abroad participants.

Experiential learning helpful to students preparing for the immersion experience was identified from past clinical and class activities including working with diverse patients in the hospital and the community along with specific course assignments. Interactions with past study abroad students over dinner and involvement in the planning and preparation phase (e.g., making arrangements to buy tickets and in securing housing) was also perceived as educational, albeit personal education, in the pre-immersion phase. Participation in a broad range of patient care activities was deemed as significant learning during the cultural interface. It is also noteworthy that students desired and sought out involvement in local events and activities in order to have a more meaningful immersion experience. In the post-immersion phase, students felt that sharing

their stories through formal and informal events (e.g., poster presentations and potlucks) was important particularly because these were key factors in their own preparation. Practical and academic suggestions for future University sponsored immersion experiences were offered from an educational perspective as well.

Except for scheduled meetings with practicum faculty and classmates, reflective opportunities in the pre-immersion phase were centered more on informal individual or small group activities where students would ask questions, share ideas, and basically talk about their upcoming experience. However, reflection through journaling and debriefing with others during the cultural interface was critical for students to begin making sense of their experiences as well as cope with stressors (cultural and academic). This continued in the post-immersion phase similarly to the pre-immersion phase, but was limited primarily because of jet lag fatigue, academic responsibilities, and graduation requirements.

Research Question 3: What is the student perception of the benefits and the gaps of the mentoring that support their cultural understanding in the preparation, cultural interface, and post-immersion stages of the global health experience? (Practical/Affective).

Students' perceptions of the mentoring that occurred pre-immersion included interactions during previous class/clinical activities, required team meetings with faculty preceptors, the international resource office personnel, former study abroad participants, physician sponsors for the immersion experience, each other, as well as their family. This changed during the cultural interface to primarily include clinical preceptors and other students traveling abroad, from the same University as well as international students whereas many of the pre-immersion mentoring activities were repeated in the post-immersion phase.

Students explicitly identified class and clinical experiences (e.g., care of diverse clients and the population health course) that were helpful to them throughout the experience; enjoyed opportunities to share their experience with fellow participants and others in all phases of the experience; had mixed reviews on how helpful pre-immersion team meetings were; and made no comment related to post-immersion debriefing meetings with practicum faculty and classmates. The international resource office personnel were also a source of support to students. However, students initially were frustrated by what they perceived as disorganization but yet recognized the value and importance of what this office provided to the program as a whole in the post-immersion phase. Although concern was expressed in the preparation phase about the placement in the curriculum of their most recent clinical prior to the actual immersion phase as well the type of clinical experiences (e.g., observation and/or hands-on) they would be able to have while abroad; students provided rich descriptions of their multi-dimensional clinical experiences abroad. In the pre-immersion phase, students were looking forward to the opportunity to gain assessment skills without the benefit of technology while abroad. Interactions with local families and in cultural events abroad were desired by all and were described as life-changing. Students emphasized the importance of their connections with other international travelers/students as well.

Research Question 4: What is the student perception of how they will integrate this global immersion experience into their personal and professional lives? (Affective).

Students offered a range of examples of how their experiences were being integrated into their personal and professional lives. Many students gained perspective on what it felt like to be an outsider in general, and in healthcare settings in particular along with how to communicate more effectively with others including, but not limited to patients, families, and other members of the

healthcare delivery team. In addition, the desire to help others whether at home or abroad, in healthcare or more universally was identified as essential in their future endeavors. Perspectives of where to work at present and in the future were changed and included recognition of healthcare system differences as well as a need for additional educational training and experiences. Students' priorities changed related to the value and appreciation of current opportunities, family, and material items. Finally, students were able to differentiate between urgent and important issues as compared to minor and/or trivial matters and incorporate their understanding of this into their personal and professional lives.

Theoretical Relevance

This section will begin with a short review of Jeffrey's cultural competence and confidence model (CCC). The results of the research study will be looked at as a whole, rather than at each specific assumption to determine whether or not there is a good fit with the model. Examples will be included as appropriate and pertinent. Key components necessary to understand the model are not repeated here, but can be located elsewhere. In particular, an illustration of the CCC model found in *Figure 1* (p. 12); assumptions related to the cultural competence and confidence model found in *Table 1* (p.13); and definitions specific to the model included in the definition of terms section can be found in Chapter One.

Jeffreys' cultural competence and confidence (CCC) model (OJCCNH.org, 2013) was selected as the organizing framework for this study and was utilized in the formulation of the research questions. Relevant empirical and conceptual literature from education (Bloom's taxonomy of learning), psychology (Bandura's self-efficacy theory), and transcultural (cross-cultural) nursing literature formed the basis for the development of this conceptual framework (Jeffreys, 2000; Jeffreys & Smoldaka, 1996; 1998; 1999; OJCCNH.org, 2013). The model

integrates transcultural skills (essential for providing culturally congruent care for clients from diverse populations [Jeffreys, 2000; OJCCNH.org, 2013]) in the cognitive, practical, and affective learning dimensions with self-efficacy (or confidence) as a key influencing factor (Douglas & Pacquiao, 2010a; 2010b; OJCCNH.org, 2013).

In general and based on the aforementioned discussion of the research questions, there is congruency between the data from the study and the assumptions of the model listed in *Table 1*. Multidimensional factors entailed in the process of learning cultural competence were identified from the data and included the following examples for each of the three learning dimensions: (a) cognitive (e.g., course work and clinical experiences, individual clinical skill level, past and current exposure to other cultures, and self-study); (b) practical (e.g., formalized language skill development such as structured classes; acquisition of common phrases in the local language(s); opportunities to practice language skills, careful listening to patients and families, and utilization of nonverbal communication with clients, at home and abroad); and (c) affective (e.g., exposure to different healthcare systems and delivery models; change in worldviews, awareness and acceptance of cultural dissimilarities, and new appreciation for the familiar).

In addition, transcultural self-efficacy (e.g., confidence), the key influencing factor of the model, was noted throughout each phase of the immersion experience as evidenced by students' attitudes (e.g., desire to learn, willingness to change, flexibility, open-mindedness, and excitement); ability to problem-solve at home and while abroad (e.g., by purchasing airline tickets and resolving housing and other issues such as stolen identification); and their overall tenacity to persevere through a myriad of details (e.g., planning, personal, academic, organizational, and cultural) they were presented with from the beginning of the immersion endeavor to the end.

Discussion of Key/New Findings

This section is divided into four primary areas: (a) personal characteristics and attributes; (b) concerns, stressors, and barriers; (c) personal and professional benefits; and (d) academic and organizational perceptions. Support for relevant literature is incorporated into each segment. A brief summary of key/new findings is included at the end of this section.

Personal Characteristics and Attributes

Although it is difficult to characterize a particular personality type most appropriate for international travel-abroad students, key attributes of benefit were described by participants. Flexibility, open-mindedness, excitement, positive attitude, growing independence along with curiosity to experience something new and a desire to travel were included in participants' descriptions from the focus group transcripts. Characteristics not explicitly described by participants, but easily gleaned from focus group discussions, student reflective journals, and researcher observations were noted and included: having the ability to problem-solve and persevere as well as be a team-player. Evidence of how these characteristics were manifested includes, but is not limited to the following: (a) ability to problem solve related to identifying communication best practices with contacts in the host country, working out leasing agreements and/or finding and making alternative arrangements for housing; managing the details of reporting and replacing stolen personal property, and resolving issues regarding clinical and preceptor arrangements; (b) demonstration of perseverance was manifested primarily in participants' self-described "Type-A" personality characteristics, completion of their academic requirements in conjunction with their ability to navigate through the myriad of details related to the immersion experience including successful resolution of the issues noted above, and (c) exemplification by participants as mentally being a team player by adhering to University and

School of Nursing guidelines for travel that included departure and arrival home dates and meeting assignment due dates/deadlines, emotionally supporting and encouraging fellow participants as well as other international students while abroad through informal debriefing sessions, and acknowledging the benefits of the processes in place for the experience even though they did not completely agree with all of the guidelines.

Wide-spread support from the literature regarding the importance of characteristics and attributes of participants in a global immersion program was not found. However, one article from the non-nursing literature examined how demographic characteristics (e.g., higher family income, parent's educational level, white ethnicity, female gender, openness to diversity, and attendance at a liberal arts University) positively influenced students' choice to participate in a study abroad program (Salisbury et al., 2009). Other than family income and parent's educational level that were not assessed, participants' demographic characteristics were similar to Salisbury et al.'s (2009) study. Barkhuizen and Feryok (2006) spoke about the importance of teamwork and communication at all levels for building relationships at home and abroad whereas in a study involving foreign language teachers (versus students), organizers of the immersion experience selected teachers (e.g., participants for the study) based on teaching commitment, intellectual curiosity, cultural interest, as well as language proficiency. Interestingly, participants in the current study exhibited a number of characteristics identified for adult learners such as being self-directed, ready to learn, and intrinsically motivated (Knowles, 1979). Howarth et al.'s (2006) study focused on the development of competent workforce teams in primary health settings. Skills and attributes recognized as important included leadership, teamwork, personal and professional development, communication, role awareness, practice development, and partnerships (Howarth et al., 2006) whereas Kim et al. (2006) focused on key competencies

needed for global leaders (e.g., flexibility, resilience, integrity, and building relationships), a number of which were identified in the study participants.

Concerns, Stressors, and Barriers

A number of concerns were expressed, stressors identified, and barriers recognized by participants throughout all phases of the immersion experience. Broadly, these were categorized as personal and academic/clinical. Personal issues will be addressed first followed by professional ones. All participants had reasonable concerns about the experience ranging from family members' apprehension for their travel; generalized fear of the unknown; potential health issues abroad from food and water, and for their personal safety. Stressors related primarily to the large number of details participants were expected to complete on their own (e.g., purchasing their own tickets), particularly in the preparation phase; safety concerns (e.g., location of housing to high crime area, transportation, and storage of personal belongings) and housing issues during the cultural interface; as well as completion of applications and interviews for jobs in the post-immersion phase. Although participants easily identified the expected communication challenges and language differences as barriers, the level of fatigue experienced in the re-entry period related to jet lag seemed unexpected based on participant comments from the focus group (e.g., difficulty staying awake during classes, staying up for 24 - 48 hours at a time, going on job interviews without sleep).

Clear description of academic concerns and stressors throughout each phase of the immersion experience was provided from participants. The required completion of a course assignment immediately prior to scheduled departure dates was challenging for participants who were finalizing preparations for their trip. Academic demands continued with multiple assignments in addition to the student reflective journals that were due while they were abroad

and after they returned (post-immersion phase). A significant barrier to completing and submitting assignments on time related to poor or lacking internet service abroad and the high user demand from other international travelers; and competing priorities in the re-entry phase with academic assignments and graduation requirements. Participants also expressed numerous concerns related to clinical experiences ranging from uncertainty about whether the experience would be hands-on or observational, practice and skill level differences, locating and working with preceptors whom they had not met, and safety and health issues such as exposure to HIV through contact with blood products.

Again, there were varying degrees of support from the literature depending on specific concerns, stressors, and barriers. Articles from anthropology and education focused on the effectiveness of programs that began at least one year ahead of time and included detailed planning for each phase of the experience that were supportive to participants (Patch & Allen, 2010; Smith, 2010; Stachowski & Sparks, 2007). Student involvement in planning study abroad programs also was identified as important to students (Wright & Larsen, 2012) and would also give them more sense of control. LaBrack (1993) stressed the need to incorporate support particularly in the largely neglected re-entry phase. Although Koskinen and Tossavainen's (2004) ethnographic study addressed issues similar to Smith (2010) and Stachowski and Sparks (2007); their conclusions also were supportive of careful re-entry planning to aid participants through the challenges in this phase. Kulbok et al.'s (2012) systematic literature review regarding immersion experience in nursing education identified program barriers such as stress and language issues, similar to the findings in this study. In a seminal study on the perception of risk in immersion programs, Morgan (2011) identified types of risks (e.g., physical) and factors influencing risk that support participants' personal concerns. Fear regarding skill level in an

immersion experience was identified as an overarching theme in Walsh and DeJoseph's (2003) study. Surprisingly, libraries are beginning to examine how they can support students abroad. For example, Wang and Tremblay (2009) and Kutner (2010) addressed issues related to how libraries need to consider providing services and support, including internet access, for students in immersion programs in an effort to assist them in completing academic requirements while abroad. This is largely because of the rising numbers of immersion programs (McKenzie et al., 2010).

Personal and Professional Benefits

Personal and professional benefits of the experience were too numerous to list in detail. However, key elements of personal benefits included growth (e.g., learning independence), changed perspectives/worldviews (e.g., understanding what it's like to be different), desire to give back to others in general, improved communication skills, and increased appreciation (e.g., for family and opportunities in life), to name a few. A variety of professional benefits were described by participants including honed assessment skills, increased sensitivity regarding healthcare costs (e.g., being less wasteful and more conscious of cost to patients), understanding healthcare systems different than their own, and improved communication with patients, their families, and other healthcare delivery team members. It is important to note two other benefits described by participants that cross over into personal and professional domains. The first benefit was the expected and hoped for change in participants related to cultural competence. There was clear delineation of participants moving through stages of cultural competence beginning with their desire to go abroad and an increased cultural awareness noted in the pre-immersion stage, to descriptions of elements of culture shock while abroad as well as acceptance of cultural differences in the affective, cognitive and practical learning domains in all phases of

the research. Secondly, participants' interactions with key persons (i.e., a person[s] who provided tangible or intangible help during all phases of the experience) were invaluable to the entirety of the immersion experience. Relationships established with key persons provided significant learning opportunities whether in the clinical setting working with a preceptor interested in helping them learn or in the formal, informal, and sometimes impromptu debriefing sessions that occurred at home and abroad.

The literature richly supports personal and professional benefits from an immersion experience. Because of the numerous examples found in the literature, only a few will be mentioned. Personal and professional benefits were evident in non-nursing literature such as in anthropology (Kinsella, 2010; Patch & Allen, 2010); education (Stachowski & Sparks, 2007); and business and marketing (Gullekson, 2011). In addition, support was found in anecdotal literature (Bosworth et al., 2006; DiFazio et al., 2009; Foronda & Belknap, 2012) as well as in research studies pertaining to nursing (Callister & Cox, 2006; Carpenter & Garcia, 2012; Sargent et al., 2005; Torsvik & Hedlund, 2008; Zorn et al., 1995). Finally, two systematic literature reviews were conducted and included relevant research on the personal and professional impact of immersion experiences spanning the years from 1980 to 2003 (Button et al., 2005) and from 2000 to 2009 (Kokko, 2011).

Academic and Organizational Perceptions

Several key components regarding the University's study abroad program emerged from the focus group data including availability of an immersion experience, type of program and placement of it in the curriculum, and the international resource office. First of all, participants expressed how their interest in studying abroad, particularly in a nursing student capacity, was of critical importance to them when identifying and choosing a University (and nursing program) to

attend. Secondly, planning for the experience began nearly a year ahead of the experience and involved team meetings with faculty advisors. In addition, placement of the immersion experience was located in the senior spring (or last) semester of their nursing curriculum and after the semester activities had started. The four-week program meant students returned to campus at or near the mid-point of the semester (e.g., around spring break). The point in time participants returned from abroad was difficult for them because of the added responsibilities of nursing license application, NCLEX preparation, and graduation to their already full schedule of academic coursework. Participants wished for an earlier start to the international practicum in part because of these added stressors that were anticipated at the beginning and because it would have given them more time to travel around the scheduled dates of the actual immersion experience. Participants offered suggestions to extend the program to eight weeks over the summer, but yet maintain the hands-on piece for future students.

Participants were appreciative of their time abroad being categorized as a practicum experience which meant they had higher level clinical skills than if they had participated as a junior nursing student. However, they were concerned about their most recent clinical being in the community versus the hospital setting.

Lastly, participants also spoke of their experiences with the international resource office personnel. Initially, participants felt frustrated by the specificity of how they were to complete travel forms and perceived a general disorganization with how the office was run, yet appreciated the help with items such as visa applications as well as the notebooks full of advice and travel tips that were available. In retrospect, participants recognized the value of the services provided and stressed the importance of the office to the future success of the study abroad programs.

A recent study was done to determine the number of nursing education programs that offered a study abroad component to their curricula (Read, 2011). Slightly less than half of the 780 schools surveyed replied with approximately 23% of respondents offering a full semester of study abroad indicating student options for international study experiences. Although it is difficult to know the exact number of nursing schools offering study abroad programs, McKenzie et al. (2010) provided guidance to planning immersion experiences for smaller universities because of the increased number of students (from multiple disciplines) participating in such programs. In addition, there is not only rich support in the literature for programmatic information regarding immersion experiences that can be utilized in the development and refinement of study abroad programs (Mason & Anderson, 2007; Mathiesen & Lager, 2007; Wright & Larsen, 2012) but also the importance of including transformative and/or experiential learning in such programs (Benner et al., 2010; Cadd, 2012; Fink, 2003; Kinsella, 2010; Kolb & Kolb, 2005).

Results of Zorn's (1996) study on the long-term impact of immersion programs support programs longer in length. Although the idea of an international resource office is not explicitly identified in the literature, there is much support for the development of partnerships and/or collaborative relationships for study abroad programs. For example, Stachowski and Sparks (2007) have a long-running (e.g., 30 year) collaborative relationship with a foundation that supports teacher education students in their immersion experiences. Furthermore, support for student involvement in designing and implementing study abroad programs is deemed important because of their role as stakeholders in the experience (Mathiesen & Lager, 2007; Wright & Larsen, 2012). Finally, principles from adult learning theories (Knowles, 1979), experiential and situated learning important to nursing as well as the creation of transformative and significant

learning experiences, also would provide support for student participation in planning and designing immersion experiences (Benner et al., 2010; Fink, 2003; Kolb & Kolb, 2005; Lave & Wenger, 1991).

Summary of Findings, Implications, Limitations and Strengths, and Future Research

Summary of Key/New Findings

This study adds to the body of literature of student immersion experiences in general, and for BSN students in particular. Study results also supported the organizing framework utilized. To date, studies focusing on student perceptions of the ability to perform, education, and mentoring needed in the preparation, cultural interface, and post-immersion phases of an immersion experience is still lacking, in the non-nursing and nursing literature alike, even though the body of knowledge is growing.

Key and/or new findings are summarized as follows: (a) personal/professional characteristics and attributes and the potential importance of this to the development of global leaders in nursing, (b) the need for technology support for students studying abroad, (c) planning specific to the re-entry period and assisting students with handling multiple priorities and jet-lag fatigue, (d) the significance of interactions with key persons to the overall success of participants individual experience as well as for the collective experience of the program, (e) the option to participate in a nursing study abroad experience, (f) the importance of resources such as the international resource office, and (g) the placement of an immersion experience within the nursing curriculum.

Implications for Practice

As universities of all sizes continue to compete for students and funding (internal and external), the option of a global immersion experience could potentially be the deciding factor

for future students, principally in healthcare fields such as nursing. Planning and preparation should begin approximately one year in advance of the experience with clear focus and detailed organization in all phases of the experience (Smith, 2010). Establishment of roles and responsibilities along with careful communication is necessary and potentially would help minimize misunderstanding, decrease stressors, and enhance clarification for all parties involved in the study abroad experience.

Strategies to help support learning, guide teaching practice and research, and evaluate effectiveness of teaching-learning strategies, also of importance to the organizing model (e.g., cultural competence and confidence model) (Douglas & Pacquiao, 2010a; 2010b; Jeffreys, 2000; 2010; OJCCNH.org, 2013) are integrated throughout this segment. There are a number of implications for practice related to the study findings that will be addressed in this section. This section is divided as follows: (a) faculty, (b) students, (c) international resource office, (d) practice limitations, and (e) academics and curriculum.

Faculty. Elements to consider in the pre-immersion phase include faculty, student, and host country and clinic site selection (if not already decided). Choice and number of faculty to oversee or lead immersion experiences is as crucial an ingredient to the success of such programs as is the international location. It should not be determined solely based on institutional budgeting or limited to the minimal requirement for faculty/student ratios in clinical experiences outlined in state practice acts for nurses (Kansas Board of Nursing Nurse Practice Act, 2012). Furthermore, suitability of faculty should be evaluated related to their interest in global immersion programs, background (e.g., past clinical and travel abroad experiences) and training, academic load, approachability, teamwork, willingness to make personal connections abroad, and communication skills (Barkhuizen & Feryok, 2006; Smith, 2010; Wright & Larsen, 2012).

Faculty willingness and ability to build relationships with facility and staff abroad allows for greater communication/follow-up in the event there are clinical (or other) performance issues with students. Training of faculty may be required and would potentially include global health concepts, public and/or community health basics, ethical-legal issues regarding nurse practice issues/limitations abroad, and intercultural communication and debriefing skills, for example. Training would be important whether faculty traveled abroad with students or supported them from afar.

Students. Participation in global immersion experiences are a means for students to gain cultural appreciation and awareness. For the participants in this study, going abroad versus being in an immersion experience in the USA was of critical importance to them. However, not all students desire a global experience to gain an understanding of cultural issues nor should everyone sign up for an international immersion experience. Although there are no clear guidelines for choosing the perfect travel abroad candidate, use of cultural assimilation (e.g., gaming and other simulated experiences), particularly in the preparation phase can assist faculty in assessing problem areas and provide opportunities to develop and/or reinforce cross-cultural skills (Juffer, 1993; McCaffery, 1993; Smith, 2010). Even though participants in this study were in a practicum versus a didactic experience, they were self-motivated to learn about their host country utilizing a variety of sources to assist them with this task. This might not be the case for other practicum students whereas requirements for an international health course would potentially include prior readings. Nonetheless, this type of preparation was beneficial and could easily be integrated into a study abroad experience regardless of whether it is a practicum or classroom experience. Meaningful assignments designed to support cultural understanding (e.g., attendance at University-sponsored poster presentations on global immersion experiences) in the

pre-immersion phase and incorporation of reflective activities such as journaling in all phases would be of value. Development of personal goals and objectives should exhibit congruency with those of the course as well.

International resource office. An international resource office was housed at the University and utilized by students enrolled in study abroad program during the course of the research study. Participants expressed concern about significant changes forthcoming related to the function of the office. Based on information gleaned from the focus group transcripts, the role of this resource office was foundational to the study abroad program, much like partnership models between universities and external agencies designed to support such programs. An international resource office would have a critical role in the preparation phase and cultural interface, as well as in the post-immersion phase. Examples of responsibilities that could potentially be incorporated into a resource office include the following: collaboration and communication with all stakeholders (e.g., students, faculty, physician sponsors, student health office, governmental agencies); securing travel visas; connection and follow-up with clinical agencies and specifically preceptors (with insight and support provided from nursing and/or other appropriate faculty); and organization of training materials and/or travel advice and tips (including safety and security issues). It is noteworthy to mention that the international resource office would have a level of understanding about application procedures for securing travel visas from each of the countries hosting students abroad that is beyond that of a person who does not regularly perform this task. Lack of understanding of the importance of this knowledge could create logistical issues and unnecessary delays in securing the necessary travel documents.

Ideally, an international resource office also would be responsible for developing, maintaining, disseminating, and implementing a contingency plan. Emergency contact

information at home and abroad (e.g., families, USA embassies, and the U.S. Department of State); clear description or definition of what constitutes a contingency situation, instructions for when and how to remove students from abroad; and a detailed outline of the chain of communication in the event of a contingency are all examples of elements that should be included in this type of plan. Furthermore, debriefing of students and/or faculty may become necessary based on difficult situations and/or contingencies experienced during the preparation and cultural interface. Faculty involved in the study abroad program need to be aware of signs and symptoms of significance related to culture shock, post-traumatic stress, or other maladjustment conditions that would alert them to the need to intervene, whether by individual counseling or referral to a trained healthcare professional. Special debriefing issues (e.g., physical harm) would need to be outlined as well. The accessibility of a medical or nursing director to assist as needed in special cases would also be beneficial.

Practice limitations. Practice limitations for students in an international setting need to be clarified with nursing faculty at home and clinical preceptors abroad prior to participation in a study abroad experience. This includes identifying the appropriateness of the travel visa (e.g., visitor, temporary resident) for this type of international travel, the length of the experience, the applicable state practice act guidelines, and the scope and standards of practice for the host country. In addition, knowledge of how preceptors abroad are trained; differences in practice; guidelines (implicit or explicit), if any, about working with individual students (e.g., related to gender issues); if they are officially licensed by the governmental entity that endorses nurses; and the legalities as to whether or not they can precept students from the USA, are critical for faculty from the sending organization to understand. It is imperative that dialogue occur between the international resource office personnel, particularly if assistance is being provided for securing

travel visas, faculty/nursing staff and preceptors abroad, and nursing faculty at home. A formal orientation to the clinic/hospital onsite and practice guidelines in the host country would be important as well. Designation of a preceptor abroad that can oversee the student's clinical experience by providing expert guidance is crucial to the success of the program. A back-up plan in the event of last minute changes (e.g., illness, death in the family) is necessary.

Consideration should be taken for establishing relationships with preceptors/sponsors that have a level of understanding of USA culture as well because of participants' positive experiences working in such situations. Related to the USA nursing faculty, other issues needing clarification are: if a faculty needs to be onsite to supervise students abroad; if a faculty is legally required to be onsite, then does the faculty also need to be licensed/endorsed to practice in the host country; if there are other, non-specified practice limitations for faculty practicing abroad; and if malpractice liabilities are covered while abroad.

Academics and curriculum. Exposure to diverse clients through clinical experiences, population health concepts, and other educational endeavors focused on cultural concepts such as the international fair should continue to be incorporated into the academic curriculum. Not all students are able to participate in a study abroad immersion program for a variety of reasons, yet immersion-type settings and programs can help enhance cultural awareness. Alternative experiences such as cultural assimilation, simulation experiences, gaming, and domestic immersion experiences with other cultures or ethnic groups also can provide students' exposure to cultural concepts and should be considered by universities as well. In addition, aspects of experiential learning such as student engagement and reflective activities should be included.

Congruency between the course description, primary objectives, assignments, and the clinical components of an academic course should exist as well, particularly if there is an

immersion experience attached to the course. Placement of the immersion experience in the curriculum should be examined in light of clinical skill level of students, availability of expert faculty, and desired length of the experience. Balance of academic/clinical experiences with informal/fun activities during the cultural interface should be considered. Furthermore, placement of the immersion experience earlier in the curriculum would potentially resolve the issues participants had dealing with multiple priorities in the immediate, but oft-neglected, re-entry phase. More importantly, this change would keep students on campus for a longer period of time allowing for extended debriefing/follow-up in the event of contingency situations. Finally, development of an elective course/clinical experience that simulated clinical in an immersion experience (e.g., focusing more broadly on critical thinking based on assessment techniques without the benefit of technology) might be beneficial for future students as well.

Limitations and Strengths

Unlike quantitative research methods, qualitative research addresses different sets of problems and questions (Marshall & Rossman, 2006; Polit & Beck, 2004). For example, this study was designed to address components considered most essential for education, training, and mentoring necessary for BSN students to be prepared for global immersion experiences rather than to answer questions with empirical data. Extensive participation in data is essential for credibility in qualitative research such as this study. Therefore, transferability of findings to other settings and/or practices should be evaluated carefully based on the nature of the study (Munhall, 2007), as well as the brevity of the immersion experiences which does not take into account the time needed for participants to move through phases of culture shock (Ryan & Twibell, 2002).

In general, participants' demographic characteristics were representative of typical nursing student populations. This also was expected by the researcher. However, study participants were essentially homogeneous and lacked diversity in terms of gender (e.g., seven of the nine participants were female), race (e.g., all but one participant were Caucasian), ethnicity (e.g., all were non Hispanic), age (e.g., ages ranged from 21-26 years), occupation (e.g., all participants were students), number of children (e.g., none), state of residence (e.g., Kansas), and birth place (e.g., primarily in the Midwest).

Moreover, participants' experiences differed from one another individually, but the cultural and country differences related to the location of the immersion experiences has to be taken into consideration as well. Furthermore, this study was based on students' perceptions from one immersion experience at a single University. Realistically, this provides only a glimpse into the research topic and should be taken into consideration when evaluating the results of the study, incorporating findings into one's own practice, and in constructing future research studies. It is important to keep in mind that neither the researcher nor the practicum faculty traveled with students to their immersion location. Although it would have been physically impossible to be in each of the countries hosting students, it would have provided valuable insight to the results of the study.

Although successful completion of doctoral level coursework with experienced qualitative researchers has been done, the researcher is still a novice qualitative researcher. As such, this researcher collected and analyzed the data which may have affected the outcomes of the study as well as transferability of the findings. In addition, a variety of circumstances (e.g., school and personal responsibilities, illness, special individual or family celebrations, and

weather-related events) could easily have affected not only individuals' willingness to participate fully in the study, but also their responses.

Strengths of the study chiefly include extended time the researcher was immersed in the data and peer and expert faculty review at each step of the data analysis process. In addition, the researcher was able to maintain objectivity from being an outsider to the undergraduate nursing program at the University. The diversity of locations where students were placed for their immersion experiences also is seen as a strength because of the variety of experiences afforded to participants.

Suggestions for Future Research

There is much support in the literature related to personal and professional benefits of an immersion experience. A logical next step would be to begin and/or continue to develop and test instruments and existing models to measure short- and long-term benefits from a personal and professional perspective. In particular, Jeffrey's cultural competence and confidence model could be further examined. For example, the strength of association between transcultural efficacy, the influencing factor, and the major constructs (i.e., affective, cognitive, and practical) could be investigated. The relationship among the affective, cognitive, and practical constructs of the model could be tested as well. The development of knowledge, skills, and attitudes necessary for quality and safety in nursing education as defined by the QSEN Institute (2013b) also could be incorporated into research. Specifically, the development of professional benefits resulting from global health immersion experiences as well as in defined competencies needed for global healthcare leaders should be included. This would help advance nursing knowledge for global healthcare leaders from previous research (Kim et al., 2006) as well as provide support for the findings from the Institute of Medicine's (2011) report on the future of nursing, such as

provision of adequately prepared nurses who are able to safely care for culturally and ethnically diverse patients, their families, and in their communities.

Research specific to student perception of risks and the challenges and special needs of the re-entry period is largely lacking in the literature and would be beneficial as well as research with greater diversity among study participants. Development and/or enhancement of cultural competence should be studied comparing students who participate in a global immersion experience as compared to students who participate in a local immersion setting. This has particular importance because of nursing education accreditation guidelines (e.g., AACN, 2008; 2013d; CCNE; 2009; NLNAC, 2012). Although a couple studies (Kardong-Edgren, 2007; Mixer, 2011) have been conducted regarding faculty perceptions related to global immersion experiences, more research in this area would be beneficial.

More research also is needed on the number of immersion programs offered in private and public liberal arts universities. For example, only one study was found in the relevant literature that had been done on the numbers of study abroad programs specific to nursing (Read, 2011). Research is needed that compares immersion programs in private versus public universities and further tests the benefits of partnerships/collaborative relationships between study abroad sites as well as universities in the same geographic area. This would be beneficial in establishing best practices for global health immersion programs. Finally, synthesis of the current nursing literature related to global immersion experiences has been sparse even though the body of literature including anecdotal accounts and research studies is growing. More research synthesizing findings from previous studies would be beneficial to gain perspective on the status of where nursing knowledge is as a whole related to this topic.

Summary

Since the professional practice of nursing is being impacted by the effects of globalization (e.g., increased numbers of culturally-diverse patients and changing healthcare needs), it is imperative for nurses to have a global perspective. The body of literature relative to global immersion experiences is growing in a wide variety of practice disciplines, in general, and in nursing, in particular. However, the number of studies focusing on BSN nursing students' perceptions found in the literature was lacking thus providing the impetus for this qualitative descriptive study. Therefore, this research has contributed to the body of nursing knowledge by describing components considered most essential in designing a short-term global healthcare immersion experience for BSN students that will enhance professional development in nursing practice in the areas of cultural understanding and global awareness. Specifically, the findings provide key information related to students' perceptions of the preparation, interface, and post-immersion phases of an immersion experience. Furthermore, these findings can be utilized by nursing education faculty and other University stakeholders to improve global healthcare immersion programs for BSN students and will contribute to efforts to shift nursing research from centering on health issues with a global component to having a broad global health perspective.

References

- Allen, L. Q. (2010). The impact of study abroad on the professional lives of world language teachers. *Foreign Language Annals*, 43, 93-104.
- American Association of Colleges of Nursing (AACN). (2008). *The essentials of baccalaureate education for professional nursing practice*. Washington DC: American Colleges of Nursing.
- American Association of Colleges of Nursing (AACN). (2013a). About AACN. Retrieved from <http://www.aacn.nche.edu/about-aacn>
- American Association of Colleges of Nursing (AACN). (2013b). Commission of Collegiate Nursing Education: Mission, values, & history. Retrieved from <http://www.aacn.nche.edu/ccne-accreditation/about/mission-values-history>
- American Association of Colleges of Nursing (AACN). (2013c). Mission and values. Retrieved from <http://www.aacn.nche.edu/about-aacn/mission-values>
- American Association of Colleges of Nursing (AACN). (2013d). Cultural competency in nursing education. Retrieved from <http://www.aacn.nche.edu/education-resources/cultural-competency>
- American Nurses Association. (2013). About ANA. Retrieved from <http://www.nursingworld.org/FunctionalMenuCategories/AboutANA.aspx>
- Amerson, R. (2010). The impact of service-learning on cultural competence. *Nursing Education Perspectives*, 31, 18-22.
- Andreatta, S., & Hu. J. (2010). Cross-cultural exchange experiences in China: Medical anthropology and community health clinical for nursing students. *Practicing Anthropology*, 32, 21-25.

Babones, S. J., & Babcicky, P. (2010). The globalization challenge to population health.

International Review of Modern Sociology, 36, 101-120.

Baillie, L. (1995). Ethnography and nursing research: A critical appraisal. *Nurse Researcher*, 3, 5-21.

Barkhuizen, G., & Feryok, A. (2006). Pre-service teachers' perceptions of a short-term international experience programme. *Asia-Pacific Journal of Teacher Education*, 34, 115-134.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco: Jossey-Bass.

Bosworth, T. L., Haloburdo, E. P., Hetrick, C., Patchett, K., Thompson, M. A., & Welch, M. (2006). International partnerships to promote quality care: Faculty groundwork, student projects, and outcomes. *The Journal of Continuing Education in Nursing*, 37, 32-38.

Button, L., Green, B., Tengnah, C., Johansson, I., & Baker, C. (2005). The impact of international placements on nurses' personal and professional lives: Literature review. *Journal of Advanced Nursing*, 50, 315-324.

Cadd, M. (2012). Encouraging students to engage with native speakers during study abroad. *Foreign Language Annals*, 45, 229-245.

Callister, L. C., & Cox, A. H. (2006). Opening our hearts and minds: The meaning of international clinical nursing electives in the personal and professional lives of nurses. *Nursing and Health Sciences*, 8, 95-102.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, 38, 203-207.

- Campinha-Bacote, J. (2007). *The process of cultural competence in the delivery of health care services: The journey continues* (5th ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.
- Carpenter, L. J., & Garcia, A. A. (2012). Assessing outcomes of a study abroad course for nursing students. *Nursing Education Perspectives*, 33, 85-89.
- Commission on Collegiate Nursing Education (CCNE). (2009). Standards for accreditation of baccalaureate and graduate degree nursing programs. Washington DC: CCNE. Retrieved from <http://www.aacn.nche.edu/accreditation/pdf/standards09.pdf>
- Commission on Social Determinants of Health (CSDH). (2007, June). *Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution; Final Report to the Commission on Social Determinants of Health*. Geneva, Switzerland: World Health Organization. Retrieved from http://www.who.int/social_determinants/resources/gkn_final_report_042008.pdf
- Commission on Social Determinants of Health. (CSDH). (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health: Final report of the Commission on Social Determinants of Health*. Geneva, Switzerland: World Health Organization. Retrieved from http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf
- Cope, P., Cuthbertson, P., & Stoddart, B. (2000). Situated learning in the practice placement. *Journal of Advanced Nursing*, 31, 850-856.
- Cornia, G. A. (2001). Globalization and health: Results and options [Special theme – Globalization]. *Bulletin of the World Health Organization*, 79, 834-841. Retrieved on from <http://www.who.int/docstore/bulletin/pdf/2001/issue9/bu1312.pdf>

- DiFazio, R., Boykova, M., & Driever, M. (2009). International education: Developing site visit guidelines to enhance understanding. *The Journal of Continuing Education in Nursing*, 40, 91-96.
- Douglas, M. K., & Pacquiao, D. F. (Eds.). (2010a). Chapter 3: Theoretical basis for transcultural nursing. Core curriculum in transcultural nursing and health care. [Supplemental material]. *Journal of Transcultural Nursing*, 21, 535-1365. doi: 10.1177/1043659610374321
- Douglas, M. K., & Pacquiao, D. F. (Eds.). (2010b). Chapter 8: Educational issues for students, organizational staff, patients, and community. Core curriculum in transcultural nursing and health care. [Supplemental material]. *Journal of Transcultural Nursing*, 21, 3385-3565. doi: 10.1177/1043659610364635
- Doyle, R. M. (2004). Applying new science leadership theory in planning an international nursing student practice experience in Nepal. *Journal of Nursing Education*, 43, 426-429.
- Drager, N., & Beaglehole, R. (2001). Globalization: Changing the public health landscape [Special theme – Globalization]. *Bulletin of the World Health Organization*, 79, 803. Retrieved from <http://www.who.int/docstore/bulletin/pdf/2001/issue9/bul488.pdf>
- Edmonds, M. L. (2012). An integrative literature review of study abroad programs for nursing students. *Nursing Education Perspectives*, 33, 30-34.
- Elo, S., & Kyngas, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62, 107-115.
- Evanson, T. A., & Zust, B. I. (2006). “Bittersweet knowledge”: The long-term effects of an international experience. *Journal of Nursing Education*, 45, 412-419.

- Falk-Rafael, A. (2006). Globalization and global health: Toward nursing praxis in the global community. *Advances in Nursing Science*, 29, 2-14.
- Fidler, D. P. (2001). The globalization of public health: The first 100 years of international health diplomacy [Special theme – Globalization]. *Bulletin of the World Health Organization*, 79, 842-849. Retrieved from <http://www.who.int/docstore/bulletin/pdf/2001/issue9/bul313.pdf>
- Fink, L. D. (2003). *Creating significant learning experiences*. San Francisco: Jossey-Bass.
- Fink, L. D., & Fink, A. K. (Eds.). (2009, Fall). *Designing courses for significant learning: Voices of experience: New directions for teaching & learning*, 119. San Francisco: Jossey-Bass Quarterly.
- Foronda, C., & Belknap, R. A. (2012). Transformative learning through study abroad in low-income countries, *Nurse Educator*, 37, 157-161.
- Forrest, S. P., & Peterson, T. O. (2006). It's called andragogy. *Academy of Management Learning & Education*, 5, 113-122.
- Furnham, A. (2010). Culture shock: Literature review, personal statement and relevance for the South Pacific. *Journal of Pacific Rim Psychology* [Special Edition – Cultural diversity across the Pacific], 4, 87-94.
- Gatzke, H., & Ransom, J. E. (2001). New skills for a new age: Preparing nurses for the 21st Century. *Nursing Forum*, 36(3), 13-17.
- Giger, J., Davidhizar, R. E., Purnell, L., Taylor Harden, J, Phillips, J., & Strickland, O. (2007). American Academy of Nursing expert panel report: Developing cultural competencies to eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing*, 18, 95-102.

- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measure to achieve trustworthiness, *Nurse Education Today*, 24, 105-112.
- Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage Publications.
- Gullekson, N. L, Tucker, M. L., Coombs, G., & Wright, S. B. (2011). Examining intercultural growth for business students in short-term study abroad programs: Too good to be true? *Journal of Teaching in International Business*, 22, 91-106.
- Haloburdo, E. P., & Thompson, M. A. (1998). A comparison of international learning experiences for baccalaureate nursing students: Developed and developing countries. *Journal of Nursing Education*, 37, 13-21.
- Heck, J. E., Bazemore, A., & Diller, P. (2007). The Shoulder to Shoulder Model: Channeling medical volunteerism toward sustainable health change. *Family Medicine*, 39, 644-650.
- Hegyvary, S. T. (2004). Working paper on grand challenges in improving global health. *Journal of Nursing Scholarship*, 36, 96-101.
- Henry, B., & Ueda, R. (2005). Learning model and curriculum designs for international health in nursing. *Japan Journal of Nursing Science*, 2, 17-24.
- Hern, M. J., Vaughn, G., Mason, D., & Weitkamp, T. (2005). Creating an international nursing practice and education workplace. *Journal of Pediatric Nursing*, 20, 34-44.
- Hodgson, I. (2001). Engaging with cultures: Reflections on entering the ethnographic field. *Nurse Researcher*, 9, 41-51.

- Horstmanshof, L., & Zimitat, C. (2007). Future time orientation predicts academic engagement among first year university students. *British Journal of Educational Psychology*, 77, 703-718.
- Howarth, M., Holland, K., & Grant, M. J. (2006). Education needs for integrated care: A literature review. *Journal of Advanced Nursing*, 56, 144-156.
- Hu, J., Andreatta, S., Yu, L., & Li, S. (2010). A collaborative international community health nursing: Clinical experience in China. *Home Health Care Management Practice*, 22, 499-506.
- Huston, C. (2008). Preparing nurse leaders for 2020. *Journal of Nursing Management*, 16, 905-911.
- Institute of Medicine (IOM). (2001, March). Crossing the quality chasm: A new health system for the 21st Century. National Academy of Sciences. Retrieved from <http://www.iom.edu/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.ashx>
- Institute of Medicine (IOM). (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press. Retrieved from http://books.nap.edu/openbook.php?record_id=12956
- Institute of Medicine (IOM). (2013). About the IOM. Retrieved from <http://www.iom.edu/About-IOM.aspx>
- International Council of Nurses (ICN). (2007). Nurse retention and migration: Position statement. Retrieved from http://www.icn.ch/images/stories/documents/publications/position_statements/C06_Nurse_Retention_Migration.pdf

International Council of Nurses (ICN). (2013). About ICN. Retrieved from

<http://www.icn.ch/about-icn/about-icn/>

Ironside, P. (2005). Working together, creating excellence: The experiences of nursing teachers, students, and clinicians. *Nursing Education Perspectives*, 26, 78-85.

Jacobson, M., & Goheen, A. (2006). Engaging students in research: A participatory BSW program evaluation. *The Journal of Baccalaureate Social Work*, 12, 87-104.

Jairath, N. (2007). Global health: The role of nursing research. *Nursing Research*, 56, 367-368.

Jeffreys, M. R. (2000). Development and psychometric evaluation of the Transcultural Self-Efficacy Tool: A synthesis of findings. *Journal of Transcultural Nursing* 11, 127-136, doi: 10. 1177/104365960001100207

Jeffreys, M. R. (2010). *Teaching cultural competence in nursing and health care* (2nd ed). New York: Springer Publishing Company.

Jeffreys, M. R., & Smoldaka, I. (1996). Steps of the instrument design process: An illustrative approach for nurse educators. *Nurse Educator*, 21, 47-52.

Jeffreys, M. R., & Smoldaka, I. (1998). Exploring the factorial composition of the Transcultural Self-Efficacy Tool. *International Journal of Nursing Studies*, 35, 217-225.

Jeffreys, M. R., & Smoldaka, I. (1999). Construct validation of the Transcultural Self-Efficacy Tool. *Journal of Nursing Education*, 38, 222-227.

Juffer, K. A. (1993). The first step in cross-cultural orientation: Defining the problem. In R. M. Paige (Ed.), *Education for the Intercultural Experience* (2nd ed.) (pp. 201-218).

Yarmouth, ME: Intercultural Press, Inc.

- Kansas Board of Nursing Nurse Practice Act. (2012, May). Nurse Practice Act statutes & administrative regulations: Requirements for approved nursing programs Statute 60-2-105(e). Retrieved from <http://www.ksbn.org/npa/npa.pdf>
- Kardong-Edgren, S. (2007). Cultural competence of Baccalaureate nursing faculty. *Journal of Nursing Education*, 46, 360-366.
- Kardong-Edgren, S., & Campinha-Bacote, J. (2008). Cultural competency of graduating U.S. Bachelor of Science nursing students. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 28, 37-44.
- Kaul, I., & Faust, M. (2001). Global public goods and health: Taking the agenda forward [Special theme – Globalization]. *Bulletin of the World Health Organization*, 79, 834-841. Retrieved from <http://www.who.int/docstore/bulletin/pdf/2001/issue9/bul1330.pdf>
- Kim, M. J., Woith, W., Otten, K., & McElmurry, B. J. (2006). Global nurse leaders: Lessons from the sages. *Advances in Nursing Science*, 29, 27-42.
- Kinsella, J. (2010). Ethnographic assessments using ethnographic fieldwork methods to help undergraduate students experience, understand, and describe living abroad. *Practicing Anthropology*, 32, 38-44.
- Kolb, A. Y., & Kolb, D. A. (2005). Learning styles and learning spaces: Enhancing experiential learning in higher education. *Academy of Management Learning & Education*, 4, 193-212.
- Knowles, M. S. (1976). Separating the amateurs from the pros in training. *Training and Development Journal*, 30, 49-51.
- Knowles, M. S. (1979). "A little historical perspective, please." *Training and Development Journal*, 33, 16-17.

- Kokko, R. (2011). Future nurses' cultural competencies: What are their learning experiences during exchange and studies abroad? A systematic literature review. *Journal of Nursing Management, 19*, 673-682.
- Kollar, S. J., & Ailinger, R. L. (2002). International clinical experiences: Long-term impact on students. *Nurse Educator, 27*, 38-31.
- Koskinen, L., & Tossavainen, K. (2003). Relationships with undergraduate nursing exchange students – a tutor perspective. *Journal of Advanced Nursing, 41*, 499-508.
- Koskinen, L., & Tossavainen, K. (2004). Study abroad as a process of learning intercultural competence in nursing. *International Journal of Nursing Practice, 10*, 111-120.
- Kuehn, A. F., Chircop, A., Downe-Wamboldt, B., Sheppard-LeMoine, D., Murnaghan, D., Elliott, J., ... Cardenas, V. (2005). Exploring nursing roles across North American borders. *North American Nursing Roles, 36*, 153-162.
- Kulbok, P. A., Mitchell, E. M., Glick, D. F., & Greiner, D. (2012). International experiences in nursing education: A review of the literature. *International Journal of Nursing Education Scholarship, 9*, 1-21.
- Kutner, L. (2010). Study-abroad programs as information producers: An expanding role for support of our students studying abroad. *Journal of Library Administration, 50*, 767-778.
- Labonte, R., & Schrecker, T. (2005, August). *Globalization and social determinants of health: Analytic and strategic review paper*. Ottawa, Canada: Institute of Population Health.
- Retrieved from http://www.who.int/social_determinants/resources/globalization.pdf
- Labonte, R., & Torgerson, R. (2005). Interrogating globalization, health and development: Towards a comprehensive framework for research, policy and political action. *Critical Public Health, 15*, 157-179.

- LaBrack, B. (1993). The missing linkage: The process of integrating orientation and reentry. In R. M. Paige (Ed.), *Education for the Intercultural Experience* (2nd ed.) (pp. 241-280). Yarmouth, ME: Intercultural Press, Inc.
- Larson, K. L., Ott, M., & Miles, J. M. (2010). International cultural immersion: En vivo reflections in cultural competence. *Journal of Cultural Diversity*, 17, 44-50.
- Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: Cambridge University Press.
- Lee, K., Koivusalo, M., Ollilo, E., Labonte, R., Schrecker, T., Schuftan, C., & Woodward, D. (2007, June). Globalization, global governance and the social determinants of health: A review of the linkages and agenda for action. *Commission on Social Determinants of Health*. Geneva, Switzerland: World Health Organization. Retrieved from http://www.who.int/social_determinants/resources/gkn_lee_al.pdf
- Leininger, M. (1997). Future directions in transcultural nursing in the 21st Century. *International Nursing Review*, 44, 19-23.
- Levitt, C., & Adelman, D. S. (2010). Role-playing in nursing theory: Engaging online students. *Journal of Nursing Education*, 49, 229-232.
- Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage.
- Loh, C. A., Steagall, J. W., Gallo, A., & Michelman, J. E. (2011). Valuing short-term study abroad in business. *Journal of Teaching in International Business*, 22, 73-90.
- Lough, B. J. (2009). Principles of effective practice in international social work field placements. *Journal of Social Work Education*, 45, 467-480.
- Lugn, N. E. (2006). Global health care – bridging the gap. *Journal of Telemedicine and Telecare*, 12, 109-110.

- Mak, D. B., Watson, R., & Hadden, J. (2011, January). Preparing medical students to undertake a cultural immersion experience: Introducing frameworks for preparatory and post-immersion activities. *International Journal for the Scholarship of Teaching and Learning*, 5(1), 1-16.
- Mann, S. J. (2001). Alternative perspectives on the student experience: Alienation and engagement. *Studies in Higher Education*, 26, 7-19.
- Marschall, S., & Davis, C. (2012). A conceptual framework for teaching critical reading to adult college students. *Adult Learning*, 23, 63-68.
- Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research* (4th ed.). Thousand Oaks, CA: Sage.
- Mason, C. H., & Anderson, M. C. (2007). Developing an international learning experience in the Gambia, West Africa: The rewards and challenges of a complex partnership. *Journal of Cultural Diversity*, 14, 35-42.
- Mathiesen, S. G., & Lager, P. (2007). A model for developing international student exchanges. *Social Work Education*, 26, 280-291.
- McAuliffe, M. S., & Cohen, M. Z. (2005). International nursing research and educational exchanges: A review of the literature. *Nursing Outlook*, 53, 21-25.
- McCaffery, J. A. (1993). Independent effectiveness and unintended outcomes of cross-cultural orientation and training. In R. M. Paige (Ed.), *Education for the Intercultural Experience* (2nd ed.) (pp. 219-240). Yarmouth, ME: Intercultural Press, Inc.
- McKenzie, R., Lopez, T., & Bowes, D. (2010). Providing international opportunities for business students: A guide to planning a short-term study abroad program at regional and small universities. *American Journal of Business Education*, 3(8), 59-65.

- McKinnon, T. H., & Fitzpatrick, J. (2011). *Global service-learning in nursing*. New York: National League for Nursing.
- McMahon, B., & Portelli, J. P. (2004). Engagement for what? Beyond popular discourses of student engagement. *Leadership and Policy in Schools, 3*, 59-76.
- McMichael, A. J., & Beaglehole, R. (2000). The changing global context of public health. *The Lancet, 356*, 495-499. Retrieved from http://www.who.int/trade/en/McMichael_Beaglehole_Changing_Global_Context_Public_Health_2000.pdf
- Merriam-Webster Online Dictionary. (2013a). Global. In *Merriam-Webster Online Dictionary*. Retrieved from <http://www.merriam-webster.com/dictionary/global>
- Merriam-Webster Online Dictionary. (2013b). Immersion. In *Merriam-Webster Online Dictionary*. Retrieved from <http://www.merriam-webster.com/dictionary/immersion>
- Merriam-Webster Online Dictionary. (2013c). International. In *Merriam-Webster Online Dictionary*. Retrieved from <http://www.merriam-webster.com/dictionary/international>
- Merriam-Webster Online Dictionary (2013d). Pedagogy. Retrieved from <http://www.merriam-webster.com/dictionary/pedagogy>
- Miettinen, R. (2000). The concept of experiential learning and John Dewey's theory of reflective thought and action. *International Journal of Lifelong Education, 19*, 54-72.
- Mixer, S. (2011). Use of the culture care theory to discover nursing faculty care expressions, patterns, and practices related to teaching culture care. *Online Journal of Cultural Competence in Nursing and Healthcare, 1*, 3-14. Retrieved from <http://www.ojccnh.org/1/1/3-14.pdf>

- Mkandawire-Valhmu, L., & Doering, J. (2012). Study abroad as a tool for promoting cultural safety in nursing education. *Journal of Transcultural Nursing*, 23, 82-89.
- Mohring, P. M. (1990). Andragogy and pedagogy: A comment on their erroneous usage. *Human Resource Development Quarterly*, 1, 93-96.
- Morgan, D. A. (2011). Student nurse perceptions of risk in relation to international placements: A phenomenological research study. *Nurse Education Today*, 32, 956-960.
- Munhall, P. (2007). *Nursing research: A qualitative perspective*, (4th ed.). Sudbury, MA: Jones & Bartlett Publishers.
- National League for Nursing (NLN). (2003, August 22). Position statement. Innovation in nursing education: A call to reform. Retrieved from <http://www.nln.org/aboutnln/PositionStatements/innovation082203.pdf>
- National League for Nursing. (2005). Core competencies for nurse educators. Retrieved from <http://www.nln.org/profdev/pdf/corecompetencies.pdf>
- National League for Nursing. (2013a). About NLN: INESA (International Nursing Education Services & Accreditation). Retrieved from <http://www.nln.org/aboutnln/globaldiversity/inesa.htm>
- National League for Nursing (NLN). (2013b). About the NLN. Retrieved from <http://www.nln.org/aboutnln/index.htm>
- National League for Nursing (NLN). (2013c). Mission/goals/core values. Retrieved from <http://www.nln.org/aboutnln/ourmission.htm>
- National League for Nursing Accrediting Commission, Inc. (NLNAC). (2010, February). Position Statement on Accreditation of International Nursing Education Programs. Retrieved from <http://nlnac.org/international/statement.htm>

National League for Nursing Accrediting Commission, Inc. (NLNAC). (2012, June).

Accreditation Manual: Assuring Quality for the future of nursing education. New York:

NLNAC, Inc. Retrieved from <http://www.nlnac.org/manuals/NLNACManual2008.pdf>

National League for Nursing Accrediting Commission, Inc. (NLNAC). (2013). About NLNAC.

Retrieved from <http://www.nlnac.org/About%20NLNAC/AboutNLNAC.htm#MISSION>

Online Journal of Cultural Competence in Nursing and Healthcare [OJCCNH.org]. (2013).

Theories & models: Marianne R. Jeffreys Cultural Competence and Confidence (CCC)

Model: A snapshot approach to frequently asked questions. Retrieved from

<http://www.ojccnh.org/project/jeffreys.shtml>

Paige, R. M. (Ed.). (1993a). *Education for the Intercultural Experience* (2nd ed.). Yarmouth, ME:

Intercultural Press, Inc.

Paige, R. M. (1993b). On the nature of intercultural experiences and intercultural education. In

R. M. Paige (Ed.), *Education for the Intercultural Experience* (2nd ed.) (pp. 1-19).

Yarmouth, ME: Intercultural Press, Inc.

Patch, K. M., & Allen, A. M. (2010). Participant observation and community engagement: An

anthropological approach to promote and assess transformative learning with NGO

internships in Ghana. *Practicing Anthropology*, 32, 32-37.

Patrick, H., & Middleton, M. J. (2002). Turning the kaleidoscope: What we see when self-

regulated learning is viewed with a qualitative lens. *Educational Psychologist*, 37, 27-39.

Patterson, J. (2007). Living the mission: Medical assistance to Nigeria. *Association of*

periOperative Registered Nurses (AORN) Journal, 86, 735-743.

Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods*, (3rd ed.). Thousand Oaks,

CA: Sage Publications.

- Peate, I. (2008). Nursing electives: An innovative and creative learning opportunity. *British Journal of Nursing*, 17, 60-63.
- Plsek, P. (1997). *Creativity, innovation, and quality*. Milwaukee, WI: ASQ Quality Press.
- Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods*, (7th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Popkess, A. M., & McDaniel, A. (2011). Are nursing students engaged in learning? A secondary analysis of data. *Nursing Education Perspectives*, 32, 89-94.
- Powers, B. A., & Knapp, T. R. (2006). *Dictionary of nursing theory and research*, (3rd ed.). New York: Springer Publishing Company, Inc.
- Priest, A. (2007). Tackling public health – at home and abroad – is a labour of love. *Canadian Nurse*, 27-28.
- Pryor, T. (2006). Health diplomacy through collaboration and a story of hope in tsunami-ravaged Banda Aceh, Indonesia: A U.S. public health service nurse officer perspective. *Military Medicine* [October Supplement], 171, 44-47.
- Pugsley, K.E., & Clayton, L. H. (2003). Traditional lecture or experiential learning: Changing student attitudes. *Journal of Nursing Education*, 42, 520-523.
- Quality and Safety Education for Nurses (QSEN) Institute. (2013a). About QSEN. Retrieved from <http://qsen.org/about-qsen/>
- Quality and Safety Education for Nurses (QSEN) Institute. (2013b). Competencies: Pre-licensure KSAs. Retrieved from <http://qsen.org/competencies/pre-licensure-ksas/>
- Quality and Safety Education for Nurses (QSEN) Institute. (2013c). The new QSEN. Retrieved from <http://qsen.org/about-qsen/the-new-qsen/>

- Quality and Safety Education for Nurses (QSEN) Institute. (2013d). Competencies: Graduate KSAs. Retrieved from. <http://qsen.org/competencies/graduate-ksas/>
- Read, C. Y. (2011). Semester abroad opportunities in Baccalaureate nursing programs. *Journal of Professional Nursing, 27*, 221-226.
- Reimer Kirkham, S., Van Hofwegen, L., & Pankratz, D. (2009). Keeping the vision: Sustaining social consciousness with nursing students following international learning experiences. *International Journal of Nursing Education Scholarship, 6*, 1-16.
- Robinson, K., Sportsman, S., Eschiti, V. S., Bradshaw, P., & Bol, T. (2006). Preparing faculty and students for an international nursing education experience. *The Journal of Continuing Education in Nursing, 37*, 21-29.
- Rodriquez, E. (2011, Winter). Reflections from an international immersion trip: New possibilities to institutionalize curriculum. *Teacher Education Quarterly, 147-160*.
- Roholt, R. V., & Fisher, C. (2013). Expect the unexpected: International short-term study course pedagogies and practices. *Journal of Social Work Education, 49*, 48-65.
- Rowenstein, A., Sweeney, C., & Gupta, R. (2012). Cross-disciplinary faculty perspective on experiential learning. *Contemporary Issues in Education Research, 5*, 139-144.
- Russell, S. S. (2006). An overview of adult-learning processes. *Urologic Nursing, 26*, 349-352, 370.
- Ryan, M., & Twibell, R. S. (2002). Outcomes of a transcultural nursing immersion experience: Confirmation of a dimensional matrix. *Journal of Transcultural Nursing, 13*, 30-39.
- Ryan, M., Twibell, R., Brigham, C., & Bennett, P. (2000). Learning to care for clients in their world, not mine. *Journal of Nursing Education, 39*, 401-408.

- Salisbury, M. H., Umbach, P. D., Paulsen, M. B., & Pascarella, E. T. (2009). Going global: Understanding the choice process of the intent to study abroad. *Research in Higher Education, 50*, 119-143.
- Salamonson, Y., Andrew, S., & Everett, B. (2009). Academic engagement and disengagement as predictors of performance in pathophysiology among nursing students. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 32*, 123-132.
- Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Nursing & Health, 23*, 334-340.
- Sandlin, J. A., Wright, R. R., & Clark, C. (2013). Reexamining theories of adult learning and adult development through the lenses of public pedagogy. *Adult Education Quarterly, 63*, 3-23.
- Sargent, S. E., Sedlak, C. A., & Martsolf, D. S. (2005). Cultural competence among nursing students and faculty. *Nurse Education Today, 25*, 214-221.
- Sellheim, D. O. (2006). Influence of Physical Therapist faculty beliefs and conceptions of teaching and learning on instructional methods. *Journal of Physical Therapy Education, 20*, 48-60.
- Sewchuk, D. H. (2005). Experiential learning: A theoretical framework for perioperative education. *Association of periOperative Registered Nurses (AORN) Journal, 81*, 1311-1318.
- Sheer, B., & Wong, F. K. Y. (2008). The development of advanced nursing practice globally. *Journal of Nursing Scholarship, 40*, 204-211.
- Souers, C. (2007). A Bolivian medical mission experience. *Association of periOperative Registered Nurses (AORN) Journal, 86*, 759-766.

- Smith, K., & Curry, K. (2011). Is it worth it? Measuring the long-term effects of an international experience for nursing students in Ecuador. *Journal of Community Health Nursing*, 28, 14-22.
- Smith, K. L. (2010). Beyond service learning: Effective approaches to field programs in applied anthropology. *Practicing Anthropology*, 32, 13-17.
- Stachowski, L. L., & Sparks, T. (2007, Winter). Thirty years and 2,000 student teachers later: An overseas student teaching project that is popular, successful, and replicable. *Teacher Education Quarterly*, 115-132.
- Swenson, M. J., Salmon, M.E., Wold, J., & Sibley, L. (2005). Addressing the challenges of the global nursing community. *International Council of Nurses: International Nursing Review*, 52, 173-179.
- Thorne, S., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Focus on qualitative methods: Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, 20, 169-177.
- Torsvik, M., & Hedlund, M. (2008). Cultural encounters in reflective dialogue about nursing care: A qualitative study. *Journal of Advanced Nursing*, 63, 389-396.
- Umbach, P. D., & Wawrzynski, M. R. (2005). Faculty do matter: The role of college faculty in student learning and engagement. *Research in Higher Education*, 46, 153-184.
- Ungos, K., & Thomas, E. (2008). Lessons learned from China's healthcare system and nursing profession. *Journal of Nursing Scholarship*, 40, 275-281.
- van Grinsven, L., & Tillema, H. (2006). Learning opportunities to support student self-regulation: Comparing different instructional formats. *Educational Research*, 48, 77-91.

- Walsh, L. V., & DeJoseph, J. (2003). "I saw it in a different light": International learning experiences in Baccalaureate nursing education. *Journal of Nursing Education*, 42, 266-272.
- Wang, B., Peng, J., Pearson, M. L., & Hubball, H. T. (2011). Internationalization of a faculty SoTL program: Immersion experiences of Beijing professors in a Canadian research-intensive university. *International Journal for the Scholarship of Teaching and Learning*, 5(2), 1-9.
- Wang, Z., & Tremblay, P. (2009). Going global: Providing library resources and services to international sites. *Journal of Library Administration*, 49, 171-185.
- Wells, M. I. (2000). Beyond cultural competence: A model for individual and institutional cultural development. *Journal of Community Health Nursing*, 17, 189-199.
- Wheatley, M. J. (1992). *Leadership and the new science: Learning about organization from an orderly universe*. San Francisco: Berrett-Koehler.
- Wheatley, M. J. (2000). What new science means to leadership. *Association for Quality & Participation*, 23, 64.
- White, J. L. (2005). Introducing undergraduate students to global health: Challenges through web-based learning. *Nursing Education Perspectives*, 26, 157-162.
- Wolf, Z. R. (2007). Ethnography: The method. In P. Munhall, *Nursing research: A qualitative perspective* (pp. 293-319). Boston: Jones & Bartlett Publishers.
- Woodward, D., Drager, N., Beaglehole, R., & Lipson, D. (2001). Globalization and health: A framework for analysis and action. *Bulletin of the World Health Organization*, 79, 875-881. Retrieved from [http://www.who.int/bulletin/archives/79\(9\)875.pdf](http://www.who.int/bulletin/archives/79(9)875.pdf)

- World Health Organization (WHO). (2012). *All for equity: World conference on social determinants of health* [Meeting Report]. Geneva, Switzerland: World Health Organization. Retrieved from http://www.who.int/sdhconference/resources/Conference_Report.pdf
- World Health Organization (WHO). (2013a) About WHO. Retrieved from <http://www.who.int/about/en/>
- World Health Organization (WHO). (2013b). Globalization. Retrieved from <http://www.who.int/trade/glossary/story043/en/index.html>
- World Health Organization (WHO). (2013c). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/
- Wright, N. D., & Clarke, I. (2010). Preparing marketing students for a global and multicultural work environment: The value of a semester-long study abroad program. *Marketing Education Review*, 20, 149-161.
- Wright, N. D., & Larsen, V. (2012). Every brick tells a story: Study abroad as an extraordinary experience. *Marketing Education Review*, 22, 121-142.
- Zorn, C. R. (1996). The long-term impact on nursing students of participating in international education. *Journal of Professional Nursing*, 12, 106-110.
- Zorn, C. R., Ponick, D. A., & Peck, S. D. (1995). An analysis of the impact of participation in an international study program on the cognitive development of senior baccalaureate nursing students. *Journal of Nursing Education*, 34, 67-70.

Appendix A

Sample Letter of Invitation

Date

Dear Student,

Volunteer student nurses participating in the *Nursing (N) 490 Professional Practicum: Study Abroad Option* elective course are needed for a research study. The primary researcher, a graduate student at the University of Kansas Medical Center, School of Nursing, will be conducting interviews to learn about educational information, training, and mentoring that

- (a) would best prepare students for an immersion experience?
- (b) is most helpful for cultural interface during the immersion experience?
- (c) is most beneficial in helping students integrate the experience into their practice in the weeks and months immediately following the experience?

Participation is completely voluntary, and student nurses must be willing to participate in two 60-90 minute focus group interviews, informal face-to-face interviews, and grant permission to the researcher to review the required reflective journal written during the immersion experience. The focus group interviews will be audio-taped and conducted in English. You may be contacted after the interview to clarify information. The study will begin in January 2012 and conclude in May 2012. Focus group interviews will be conducted at the University of Kansas School of Nursing at a time that is convenient for you. Information will remain confidential, and your name will never be used. If information is used in the write-up of the report, participants will be identified with the use of pseudonyms. Finally, the researcher will not have any influence or role in evaluating students for this course.

If you are interested, please contact Kathryn (Kathi) Czanderna at kczanderna@kumc.edu for more information. A copy of the *Research Consent* form is available upon request and will be reviewed prior to the beginning of the study. This study has been reviewed and received approval from the Institutional Review Board at the University of Kansas Medical Center.

Thank you for this consideration.

Sincerely,
Kathryn (Kathi) Czanderna

University of Kansas, School of Nursing

Appendix B

RESEARCH CONSENT

TITLE: A Qualitative Study on the Impact of a Short-Term Global Healthcare Immersion Experience
in Bachelor of Science Nursing (BSN) Students

You are being asked to join a research study. You are being asked to take part in this study because you are a student nurse enrolled in the *Nursing (N) 490 Professional Practicum: Study Abroad Option* course at the University of Kansas School of Nursing (KU SoN). You do not have to participate in this research study. The main purpose of research is to create new knowledge for the benefit of future patients and society in general. Research studies may or may not benefit the people who participate.

Participation is voluntary, and you may change your mind at any time. There will be no penalty to you if you decide not to participate, or if you start the study and decide to stop early. Either way, you will still receive education and services at KU SoN and not participating will also have no affect on your current or future course grades while a student.

This consent form explains what you have to do if you are in the study. It also describes the possible risks and benefits. Please read the form carefully and ask as many questions as you need to, before deciding about this research. You can ask questions now or anytime during the study. The researcher(s) will tell you if they receive any new information that might cause you to change your mind about participating.

This research study will take place at KU SoN as a component of program requirements for the KU School of Nursing PhD program. A total of up to 14 participants are needed for the proposed study.

BACKGROUND

Cultural sensitivity is an important attribute desired of the nursing profession. Educational endeavors such as a global healthcare immersion experience are being used to help develop cultural competence. Although research has been conducted in this area there is lack of consistency in understanding student perspectives and perceptions of the preparation, immersion, and post immersion phases of a global healthcare immersion experience. In addition, greater understanding of the impact of a global immersion experience on the personal and professional lives of nurses is needed. This research could provide further knowledge about the short- and long-term impact of such an experience vital to the practicing nurse. Increased knowledge in this area could support efforts to develop culturally and ethnically competent care of diverse patient populations. Without baseline knowledge, it is impossible to develop education or interventional strategies in nursing. This research could provide a foundation for learning more about culturally sensitive care that can be used for future knowledge and interventions in practice.

PURPOSE

By doing this study, researchers hope to learn about the preparation for the global healthcare immersion experience (GHIE), its impact on BSN students cultural awareness and the personal and professional lives of nurses in order to obtain a better understanding for its meaning for nurses.

PROCEDURES

If you are eligible and decide to participate in this study, your participation will last during the length of the semester. Your participation will involve...

- A maximum of two focus group interviews (e.g. one in the pre-immersion phase and one in the post-immersion phase) lasting 60-90 minutes with the researcher and/or research assistant asking questions regarding the preparation for the immersion experience, cultural awareness gained during the immersion experience, and personal and professional benefits of a global healthcare immersion experience.
 - A total of four focus groups will be scheduled (two at pre-immersion and two at post-immersion). Participants will choose to attend one of two focus groups offered during the pre-immersion phase and one of two focus groups offered in the post-immersion phase.
 - Focus groups include semi-structured interview questions presented to small groups of participants for the purpose of learning more about a particular topic.
- Agreement for the participant to protect the confidentiality of information obtained from the focus groups sessions.
- A 15-20 minute follow-up interview may be asked of you to clarify or seek further information provided in the focus groups.
- The interviews will be recorded and transcribed by the researcher or research assistant. Your identity will be held in confidence by using a numbered code as the identity marker for your transcribed interview comments and only known to the researcher(s).
- Agreement for the researcher to review the required reflective journal completed during the global healthcare immersion experience.
- You will be asked a short series of questions regarding your demographic information such as gender, age, ethnic background, birthplace and number and reasons for trips outside of the United States of America.

RISKS

You may feel uncomfortable discussing your global healthcare immersion experience. At any point you are not comfortable you may skip a question or stop participating all together. The treatment of the information will be confidential. In order to minimize these risks, your information will be kept confidential. You are free to give only the information you choose to and will be maintained by the researcher(s). In addition,

- All recordings will be destroyed after the analysis of the data is completed.
- The transcriptions of recordings from each interview will be maintained in a secured file at the University of Kansas, School of Nursing as required by the research review board and then destroyed.

NEW FINDINGS STATEMENT

You will be told about anything new that might change your decision to be in this study. You may be asked to sign a new consent form if this occurs.

BENEFITS

You will not directly benefit from participating in this research study. Researchers hope that the information obtained in this study will enhance the practice of nursing to enhance patient outcomes for those receiving nursing care.

ALTERNATIVES

Participation in this study is voluntary. Deciding not to participate will have no effect on your relationship with the researcher or services you receive at the University of Kansas Medical Center (KUMC) and not participating will also have no affect on current or future employment with KUMC or on your academic endeavors at KUMC.

COSTS

There is no cost for being in the study.

PAYMENT TO SUBJECTS

Pizza and soft drinks will be provided during each of the focus groups.

INSTITUTIONAL DISCLAIMER STATEMENT

If you think you have been harmed as a result of participating in research at the University of Kansas Medical Center (KUMC), you should contact the Director, Human Research Protection Program, Mail Stop #1032, University of Kansas Medical Center, 3901 Rainbow Blvd., Kansas City, KS 66160 .Under certain conditions, Kansas state law or the Kansas Tort Claims Act may allow for payment to persons who are injured in research at KUMC.

CONFIDENTIALITY

The researchers will protect your information, as required by law. Absolute confidentiality cannot be guaranteed because persons outside the study team may need to look at your study records. The researchers may publish the results of the study. If they do, they will only discuss group results. Your name will not be used in any publication or presentation about the study. Involvement or lack of involvement in the study will not affect the final grade for the course. Course faculty will never see the focus group or informal interview transcripts.

SUBJECT RIGHTS AND WITHDRAWAL FROM THE STUDY

You may stop being in the study at any time. The entire study may be discontinued for any reason without your consent by the investigator(s) conducting the study.

QUESTIONS

Before you sign this form, Dr. Marge Bott or Kathryn Czanderna, should answer all your questions. You can talk to the researchers if you have any more questions, suggestions, concerns or complaints after signing this form. If you have any questions about your rights as a research subject, or if you want to talk with someone who is not involved in the study, you may call the Human Subjects Committee at (913) 588 1240. You may also write the Human Subjects

Committee at Mail Stop #1032, University of Kansas Medical Center, 3901 Rainbow Blvd.,
Kansas City, Kansas 66160

CONSENT

Dr. Marge Bott or Kathryn Czanderna has given you information about this research study. If you have questions about this study, you may contact Dr. Bott at 913-588-1692. They have explained what will be done and how long it will take. They explained any inconvenience, discomfort or risks that may be experienced during this study. You will be given a copy of the consent form to keep for your records.

Participant Printed Name
Participant

Date and Time

Signature of

Name of person obtaining consent
obtaining consent

Date and Time

Signature of Person

Appendix C

RESEARCH CONSENT
(Post-Immersion Focus Group)

TITLE: A Qualitative Study on the Impact of a Short-Term Global Healthcare Immersion Experience
in Bachelor of Science Nursing (BSN) Students

You are being asked to join a research study. You are being asked to take part in this study because you are a student nurse enrolled in the *Nursing (N) 490 Professional Practicum: Study Abroad Option* course at the University of Kansas School of Nursing (KU SoN). You do not have to participate in this research study. The main purpose of research is to create new knowledge for the benefit of future patients and society in general. Research studies may or may not benefit the people who participate.

Participation is voluntary, and you may change your mind at any time. There will be no penalty to you if you decide not to participate, or if you start the study and decide to stop early. Either way, you will still receive education and services at KU SoN and not participating will also have no affect on your current or future course grades while a student.

This consent form explains what you have to do if you are in the study. It also describes the possible risks and benefits. Please read the form carefully and ask as many questions as you need to, before deciding about this research. You can ask questions now or anytime during the study. The researcher(s) will tell you if they receive any new information that might cause you to change your mind about participating.

This research study will take place at KU SoN as a component of program requirements for the KU School of Nursing PhD program. A total of up to 14 participants are needed for the proposed study.

BACKGROUND

Cultural sensitivity is an important attribute desired of the nursing profession. Educational endeavors such as a global healthcare immersion experience are being used to help develop cultural competence. Although research has been conducted in this area there is lack of consistency in understanding student perspectives and perceptions of the preparation, immersion, and post immersion phases of a global healthcare immersion experience. In addition, greater understanding of the impact of a global immersion experience on the personal and professional lives of nurses is needed. This research could provide further knowledge about the short- and long-term impact of such an experience vital to the practicing nurse. Increased knowledge in this area could support efforts to develop culturally and ethnically competent care of diverse patient populations. Without baseline knowledge, it is impossible to develop education or interventional strategies in nursing. This research could provide a foundation for learning more about culturally sensitive care that can be used for future knowledge and interventions in practice.

PURPOSE

By doing this study, researchers hope to learn about the preparation for the global healthcare immersion experience (GHIE), its impact on BSN students cultural awareness and the personal and professional lives of nurses in order to obtain a better understanding for its meaning for nurses.

PROCEDURES

If you are eligible and decide to participate in this study, your participation will last during the length of the semester. Your participation will involve...

- One focus group interview (e.g. one in the post-immersion phase) lasting 60-90 minutes with the researcher and/or research assistant asking questions regarding the preparation for the immersion experience, cultural awareness gained during the immersion experience, and personal and professional benefits of a global healthcare immersion experience.
 - A total of two focus groups will be scheduled at post-immersion. Participants will choose to attend one of two focus groups offered in the post-immersion phase.
 - Focus groups include semi-structured interview questions presented to small groups of participants for the purpose of learning more about a particular topic.
- Agreement for the participant to protect the confidentiality of information obtained from the focus groups sessions.
- A 15-20 minute follow-up interview may be asked of you to clarify or seek further information provided in the focus groups.
- The interviews will be recorded and transcribed by the researcher or research assistant. Your identity will be held in confidence by using a numbered code as the identity marker for your transcribed interview comments and only known to the researcher(s).
- Agreement for the researcher to review the required reflective journal completed during the global healthcare immersion experience.
- You will be asked a short series of questions regarding your demographic information such as gender, age, ethnic background, birthplace and number and reasons for trips outside of the United States of America.

RISKS

You may feel uncomfortable discussing your global healthcare immersion experience. At any point you are not comfortable you may skip a question or stop participating all together. The treatment of the information will be confidential. In order to minimize these risks, your information will be kept confidential. You are free to give only the information you choose to and will be maintained by the researcher(s). In addition,

- All recordings will be destroyed after the analysis of the data is completed.
- The transcriptions of recordings from each interview will be maintained in a secured file at the University of Kansas, School of Nursing as required by the research review board and then destroyed.

NEW FINDINGS STATEMENT

You will be told about anything new that might change your decision to be in this study. You may be asked to sign a new consent form if this occurs.

BENEFITS

You will not directly benefit from participating in this research study. Researchers hope that the information obtained in this study will enhance the practice of nursing to enhance patient outcomes for those receiving nursing care.

ALTERNATIVES

Participation in this study is voluntary. Deciding not to participate will have no effect on your relationship with the researcher or services you receive at the University of Kansas Medical Center (KUMC) and not participating will also have no affect on current or future employment with KUMC or on your academic endeavors at KUMC.

COSTS

There is no cost for being in the study.

PAYMENT TO SUBJECTS

Pizza and soft drinks will be provided during each of the focus groups.

INSTITUTIONAL DISCLAIMER STATEMENT

If you think you have been harmed as a result of participating in research at the University of Kansas Medical Center (KUMC), you should contact the Director, Human Research Protection Program, Mail Stop #1032, University of Kansas Medical Center, 3901 Rainbow Blvd., Kansas City, KS 66160 .Under certain conditions, Kansas state law or the Kansas Tort Claims Act may allow for payment to persons who are injured in research at KUMC.

CONFIDENTIALITY

The researchers will protect your information, as required by law. Absolute confidentiality cannot be guaranteed because persons outside the study team may need to look at your study records. The researchers may publish the results of the study. If they do, they will only discuss group results. Your name will not be used in any publication or presentation about the study. Involvement or lack of involvement in the study will not affect the final grade for the course. Course faculty will never see the focus group or informal interview transcripts.

SUBJECT RIGHTS AND WITHDRAWAL FROM THE STUDY

You may stop being in the study at any time. The entire study may be discontinued for any reason without your consent by the investigator(s) conducting the study.

QUESTIONS

Before you sign this form, Dr. Marge Bott or Kathryn Czanderna, should answer all your questions. You can talk to the researchers if you have any more questions, suggestions, concerns or complaints after signing this form. If you have any questions about your rights as a research subject, or if you want to talk with someone who is not involved in the study, you may call the Human Subjects Committee at (913) 588 1240. You may also write the Human Subjects Committee at Mail Stop #1032, University of Kansas Medical Center, 3901 Rainbow Blvd., Kansas City, Kansas 66160

CONSENT

Dr. Marge Bott or Kathryn Czanderna has given you information about this research study. If you have questions about this study, you may contact Dr. Bott at 913-588-1692. They have explained what will be done and how long it will take. They explained any inconvenience, discomfort or risks that may be experienced during this study. You will be given a copy of the consent form to keep for your records.

Participant Printed Name
Participant

Date and Time

Signature of

Name of person obtaining consent
obtaining consent

Date and Time

Signature of Person

Appendix D

Demographic Questionnaire

Subject Number: _____

Please answer the following questions with as much detail as you would like to share.

1. Gender (Circle one)
 - a. male
 - b. female
2. Prior Education (Circle one)
 - a. High School
 - b. Some vocational
 - c. Associates degree
 - d. Bachelors degree in other field
 - e. Graduate degree in other field
3. Marital Status (Circle one)
 - a. Single
 - b. Married
 - c. Widowed
 - d. Divorced
4. Children (Circle one)
 - a. None
 - b. One
 - c. Two or more
5. Race (Circle one)
 - a. African-American
 - b. Asian
 - c. Caucasian
 - d. Native American
 - e. Other: List: _____
6. Ethnicity (Circle one)
 - a. Hispanic
 - b. Non-Hispanic
7. Age _____
8. Employment (Circle one)
 - a. Yes
 - i. If yes, usual number of hours worked per week? _____
 - b. No
9. State/Country of Permanent Residence _____

10. Place of Birth_____

11. Number of trips taken outside of the United States_____

a. If none, check here: _____

12. Reason for trips taken outside of the United States (circle all that apply)

a. Vacation/holiday

b. Missions work

c. Military service

d. Business travel

e. Other, please

describe_____

13. Length of time (in days or weeks) spent outside of the United States

14. Source(s) of funding for immersion experience-

a. Self/spouse

b. Parents

c. Other, please

describe_____

15. Proportion of trip that was self paid. (Circle one)

a. 0%

b. 1 – less than 25%

c. 25 – less than 50%

d. 50 – less than 75%

e. 75 – less than 99%

f. 100%

Appendix E

Interview Guide

The role of the interviewer is to allow the participant to provide descriptions of the phenomena of interest with limited prompting. The main areas of concern are listed below. The interviewer should use techniques to encourage continued description from participants such as silence, seeking clarification, use of non-verbal cues as needed, but preserve empathetic impartiality.

The specific research questions that would support this aim are:

- (a) What is the student perception of his/her ability to perform in a global health setting in the preparation, cultural interface, and post-immersion stages? (Self-efficacy)
- (b) What is the student perception of the educational information including clinical training that is needed in the preparation, cultural interface, and post-immersion stages of the global health experience? (Cognitive/Practical)
- (c) What is the student perception of the benefits and the gaps of the mentoring that support their cultural understanding in the preparation, cultural interface, and post-immersion stages of the global health experience? (Practical/Affective)
- (d) What is the student perception of how they will integrate this global immersion experience into their personal and professional lives? (Affective)

Pre-immersion focus group interview questions:

- 1) Tell me what led you to participate in the immersion experience?

What immersion experiences have you had in the past?

- 2) How would you describe your preparation for the immersion experience?
- 3) Give me an example of the type of preparation you have had for the immersion experience.

Tell me what you have experienced in preparation for the immersion

- 4) How do you feel you will be able to perform in a global health setting?

What example would you be willing to share to illustrate this?

- 5) What part of your preparation do you believe will help you the most during the immersion experience?

What example would you be willing to share to illustrate this?

- 6) What else would you like to add?

Post-immersion focus group interview questions:

- 1) What do you believe helped you the most
 - a.) in preparing for the immersion experience?
 - b.) during the immersion experience?
 - c.) and after returning home?

What example would you be willing to share to illustrate this?

- 2) How would you describe the impact of the global immersion experience on you personally?
Professionally?

Tell me about what led you to participate in this experience.

What example would you be willing to share to exemplify this?

- 3) How would you describe the training and preparation you had for the global immersion experience?
- 4) What part(s) of your education, training and preparation is/was most helpful for your cultural awareness and understanding?

What example would you be willing to share to illustrate this?

- 5) What was the most helpful in preparing you for the immersion experience?
- 6) In the mentoring you received in preparing you for the immersion experience
 - a. What was helpful?
 - b. What was missing? Or what were the gaps?
- 7) What else would you like to add?

Appendix F

Reflective Journaling of the Researcher

The researcher set aside personal experience, biases, and expectations prior to the beginning of data collection and maintained objectivity through continued reflexive journaling throughout the study. However, perspective gained from her preparation for and experience in living and working abroad for five years in the developing country of Papua New Guinea is of value and will now be included.

First of all, it is no small feat to organize and manage the myriad of details of a travel abroad experience for any reason, of any length, and for all involved. It requires patience, flexibility, and more often than not, sheer tenacity in completing the tasks. Planning a travel abroad experience in the middle of an educational program is no exception. Admiration was felt for participants because of their constant positivity, exuberance as well as their ability to complete tasks, move beyond the difficult, and still have what they described as a great and life-changing experience and for faculty preceptors for managing the clinical details as well as communicating information to and from the researcher related to the study. Empathy was also felt. The researcher began to plan for an immersion experience in conjunction with her proposed research and then again when circumstances changed at her workplace creating a need for a second faculty member to travel abroad with a healthcare team. In both situations, the researcher felt excitement for the experience, but apprehension regarding the plethora of personal (e.g., updating vaccinations, securing travel documents, planning communication with family) and professional (e.g., work responsibilities, doctoral studies) tasks involved because she knew from past experience the time and energy that would have been required to complete them.

Sorting through details related to basic physiological (food, shelter) and safety needs can be unsettling and negatively impact a person. It was surprising to the researcher to hear how much these basic needs were unmet (at least in part) at the beginning of and in some cases, throughout, the cultural interface. It is hard to imagine that this did not affect participants more than they described. One clue regarding this relates to a participant who verbalized experiencing an unplanned, significant weight loss during the immersion experience citing stress as a contributing factor. Recollection of course work taken in preparation for the researcher's own immersion experience reinforces the need to feel settled and safe, have some semblance of normalcy such as through established routine, and be sufficiently rested, well-hydrated, and properly fed (to help ward off the effects of jet-lag).

Issues pertaining to safety and security were expressed by all participants albeit in varying degrees. Although this was not surprising per se, the participant with the unplanned weight loss has remained in the forefront of this researcher's mind because of her belief that this participant could have benefitted from more intentional and/or expert debriefing with faculty and/or others. During the researcher's time living abroad, she faced numerous stress-producing situations related to personal safety and security, several of which could be categorized as life-threatening. Co-workers and agency personnel recognized that the circumstances necessitated assistance even prior to the researcher's own awareness of this need. Fortunately, support was obtained through expert-led debriefing sessions, in a neutral setting, that guided the researcher to a deeper level of understanding in this area. The aforementioned situations provide strong support for contingency plans to be in place regardless of how safe a country may seem.

It is difficult to know what the right mix of personality characteristics and attributes should be with team members traveling abroad. From personal experience, the make-up of a

team can have a significant effect on the overall quality of the experience individually and collectively. In the preparation for her own immersion experience, the researcher was evaluated and assessed extensively in a number of ways and in a variety of situations. Multiple methods of evaluation were utilized primarily over the course of a week-long simulation experience including but not limited to the following: personality, spiritual, and risk assessments; social interaction in team activities as well as during meals; responses to the unexpected black-outs or lack of water; and in individual, family, and team meetings and reflections. The purpose was to identify areas of concern and risk that could escalate while abroad and potentially create difficulties with self and others (e.g., family, team members, and the local community abroad) and establish plans to effectively deal with these issues prior to immersion on the field. Although, this was not a fool-proof system, it did help to screen participants who were unsuited for such an experience and served as a means of identifying individual and family strengths and limitations. A modified version of this type of screening could prove to be beneficial for universities as well.

Finally, understanding and planning for the legal issues of practicing abroad is imperative. The researcher's primary work responsibility while abroad was as the hospital administrator of a nongovernmental hospital. Documentation of nursing licensure, awarded degrees and certifications, and continuing education were all part of what was required in order to obtain a visa that permitted the researcher to work. However, the researcher was not automatically able to practice nursing while abroad until she applied for and met the competencies required for licensure in the host country. In addition, the researcher's nursing malpractice and liability insurance policy also did not provide coverage during the time she was abroad. No other options for coverage were available at the time.

In summary, the researcher appreciates the work of the faculty in charge of the international practicum for opening the gate and being able to enter into this experience; assistance in gathering student reflective journals, communication support with students; and shared insights. More importantly, the researcher is deeply grateful for students' willingness to participate in the study along with their candid and enthusiastic responses. The insight gained from their stories also has served to validate the meaning of the researcher's own experiences abroad.

Appendix G

Student Reflective Journaling Course Requirements

CLINICAL JOURNAL GUIDELINES**Journal Objectives:**

Each student will be keeping a journal. Brief entries need to be made for each clinical day following the guidelines in the course syllabus. Weekly journals are due each Monday during your international experience abroad. Briefly share your daily clinical experiences and reaction to your learning experiences and any issues that need to be addressed. Three journals with specific questions re: your clinical site will be due in Feb. When you resume your practicum experience in KC, your weekly log will take the place as a weekly clinical site visit. At that time, the remaining 3 assigned journals will be the only logs due for March and April.

Journal 1 (Required)

Topics:

1. Describe your orientation to the new culture, housing, and clinical setting. What challenges have you identified so far? What professional skills have you used to address the cultural challenges/issues?
2. Describe your unit or clinical area. Include the patient population served, most commonly seen patient diagnosis and procedures done. What are the physical characteristics of this nursing unit or clinical area (number of beds, rooms, location of supplies, and other items of physical plan interest)?
3. Describe your preceptor. How did you meet? What was your first impression? What is their background? How long have they been a nurse, where did they graduate from, how long have they been in this position, what are their plans for the future, what would they like to see you be able to do at the end of this semester?
4. Select one patient you cared for this week and:
 - a. Give the medical diagnosis
 - b. List the meds, their dosages, routes, and schedule of administration.
 - c. Group the meds into classifications and describe the mechanisms of action and common side effects for each class.
 - d. Note anything else of particular interest about this person's medication, such as method of storage, administration, half-life, etc.
 - e. What is the most important thing you are concerned about regarding this person and their medications?
 - f. How would you resolve this concern?

5. List the clinical dates and number of hours you have worked this week. Describe your clinical experience this week.
6. What is to one thing you have learned since starting the Practicum course that you believe has best prepared you to pass the NCLEX?
7. What is the one thing you have learned since starting the Practicum course that you believe will assist you in making the transition to the RN role?

Journal 2 (Required)

Topics:

1. Describe your ability to adjust to a different cultural environment this week. What issues/challenges have you experienced at your international setting such as transportation, schedules, housing, food, etc? What strategies and professional skills have you used to address these issues?
2. Describe your ability to relate to others (preceptor, staff, other international students, etc.).
3. Select one patient you cared for this week and:
 - a. Give the medical diagnosis.
 - b. List the meds, their dosages, routes, and schedule of administration.
 - c. Group the meds into classifications and describe the mechanisms of action and common side effects for each class.
 - d. Note anything else of particular interest about this person's medication, such as method of storage, administration, half-life, etc.
 - e. What is the most important thing you are concerned about regarding this person and their medications?
 - f. How would you resolve this concern?
4. List the health issue you have identified for your poster presentation. What information have you already gathered? What additional information, contacts, and interviews, etc. do you need to gather before you depart from your international site?
5. List the clinical dates and number of hours you have worked this week. Describe your clinical experience this week.

Journal 3 (Required)

Topics:

1. Select one of the patients you cared for this week and summarize the following:
 - a. Primary reason for seeking help?
 - b. Brief history of current illness.
 - c. Primary nursing diagnosis and medical diagnosis. What subjective and objective data does this patient present with that supports these diagnoses?
 - d. Describe the nursing and medical treatments that are being done for this patient. Of all these treatments what is the most important?
 - e. What is this patient's outlook for a healthy productive life? (Prognosis)
 - f. What do you need to do as an RN now that will best help this person achieve a healthy, productive life?
2. Observe the activities of the nurses in your area and note at least four techniques used to increase their efficiency. What techniques have you developed since the start of this clinical that has increased your efficiency?
3. List the clinical dates and number of hours you have worked this week. Describe your clinical experience this week.
4. What is the one thing you have learned since the last journal entry that you believe has best prepared you to pass the NCLEX?
5. What is the one thing you have learned since the last journal entry that you believe will assist you in making the transition to the RN role?

Journal 4 (Optional)

Topics:

1. Select one of the patients you cared for this week and summarize the following:
 - a. Primary reason for seeking help?
 - b. Brief history of current illness.
 - c. Primary nursing diagnosis and medical diagnosis. What subjective and objective data does this patient present with that supports the diagnosis?
 - d. Describe the nursing and medical treatments that are being done for this patient. Of all these treatments what is the most important?
 - e. What is this patient's outlook for a healthy productive life? (Prognosis)
 - f. List examples for each of these areas; cultural, economic, political, ethical, legal, and organizational that you considered as you were providing care for this patient.
2. Locate the organizational chart for nursing service in your facility and find where your preceptor fits. Now locate who your preceptor's manager is on this chart. Next locate the manager's boss. Keep going up the chart until you reach the top. Discuss this chart

with your preceptor and other staff on your unit. Find out the opinions of the staff in your units about each of these people. What is the predominate feeling the nursing staff have towards the unit leader, Nursing department leader, and leader/s of the hospital/healthcare organization? Do you agree with this? What examples can you give that have shaped your opinion on this issue?

3. How is shift report done in your area? What information are you getting in report that you don't need? What information are you not getting that you do need? What 3 suggestions do you have for improving the report process on your unit?
4. List the clinical dates and number of hours you have worked this week.
5. What is the one thing you have learned since the last journal entry that you believe has best prepared you to pass the NCLEX?
6. What is the one thing you have learned since the last journal entry that you believe will assist you in making the transition to the RN role?
7. What are your plans for Spring Break?